With This Issue Part II

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Part I

REHABILITATION LITERATURE

National Society for
Crippled Children and Adults

Review Articles

Book Reviews

Digests

Abstracts

Events and Comments

Rehabilitation Literature is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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REHABILITATION LITERATURE

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PART TWO

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REHABILITATION LITERATURE

Article of the Month

Some Issues Concerning Psychology and Rehabilitation

Beatrice A. Wright, Ph.D.

Constance Scheerer Photo

About the Author . . .

Dr. Wright is now psychological consultant to nursery schools, Kansas City, Kan., and to the Institute for Parents of Young Deaf Children, Olathe, Kan., and chairman of the Joint Advisory Curriculum Committee for Lawrence, Kan., public schools. Her background includes research and teaching at Stanford University, San Francisco State College, and Swarthmore College; parent education; and employment counseling. Dr. Wright received her M.A. (1940) and her Ph.D. (1942) degrees in psychology from the State University of Iowa. In 1953 she became research associate in psychology at the University of Kansas, where she completed her recent book Physical Disability—A Psychological Approach. In 1955-58 she edited the Bulletin of the National Council on Psychological Aspects of Disability. The book Psychology and Rehabilitation, reporting the Princeton conference of psychologists and published by the American Psychological Association (1959), was edited by her. For the 1960-61 academic year, she, her husband Erik, and their three children are in Perth, Australia. Dr. Erik Wright will serve as Fulbright lecturer in mental health at the University of Western Australia.

This original article was written especially for Rehabilitation Literature.

IN FEBRUARY, 1958, a study group of 54 psychologists and 12 representatives from allied fields gathered together for a 5-day period to consider the role of psychology and psychologists* in rehabilitation. The topics discussed were vital. Problems in education and training, in role definition on the job, in research priorities and strategies, in interprofessional relations, and in the conception of rehabilitation itself beset the Institute. Many of the issues proved to have important implications, not only for psychologists but for all professionals working in rehabilitation. Several among these are considered below. Since the opportunity has been taken in the present review to elaborate and draw additional implications from the proceedings of the Institute, not all the statements herein can be ascribed to the Institute as such. The full report of the Institute appears in Wright *(1959)*.

The Framework of Rehabilitation

Short definitions of rehabilitation offer a first approximation from which modification and elaboration can begin to clarify its scope and nature. Such clarification is necessary for evaluating current programs and improving the functions and preparation of skilled personnel in this field. The following are well-known brief statements about rehabilitation:

Rehabilitation means restoration to individual and social functioning following impairments.

Rehabilitation refers to the restoration to a satisfactory physical,

*The Institute, sponsored by the American Psychological Association and the Office of Vocational Rehabilitation, primarily concerned itself with the psychologist at the doctoral level.

mental, vocational, or social status after injury or illness, including mental illness and congenital malfunctioning.

Rehabilitation emphasizes the reintegration of the individual into the community on the most efficient and useful level of adjustment possible.

Rehabilitation is the third phase of medicine (the first two being prevention and treatment) in which emphasis is placed on adjustment to residual disability rather than reversal of illness or injury.

An objection to such definitions has been that they are too broad, too vague, and insufficiently definitive. In regard to the last definition, the points have also been made that coping with the impact of trauma cannot be set aside until the patient is otherwise "treated" and that rehabilitation cannot divorce itself from prevention by excluding the role of premorbid attitudes and societal values in relation to disability. Nonetheless, such definitions, together with a knowledge of the action programs that have come to be part of the rehabilitation of persons with physical, mental, and emotional disabilities, enable us to go further in an attempt to make explicit the principles and assumptions that have given direction to the rehabilitation movement. Of these, a "basic dozen" are:

1. *Value of the human being.* The human being is a being of worth to be respected and cherished, no matter how severe his disabilities may be. He has a right to be assisted in the unfolding of his personality and the development of his potentialities for his own sake and for the good of society.

2. *Membership in society.* The very nature of life implies physical and mental variation. Persons with a disability, like anyone else, should partake of the activities that society has to offer. Separation is indicated only under the considered evaluation of personal and social welfare, and then only as a temporary expedient until reabsorption into the community at large is possible. Acceptance on the part of society, rather than aversion and fear, is the emotional attitude toward which the rehabilitation effort is directed.

3. *Assets of the person.* Although man is beset with physical and mental attributes that often interfere with his well-being, he also has a hearty complement of assets that can be supported and developed. The pathological processes in man's physical and mental makeup destroy; the healthy components restore. Emphasis on the latter is a formidable ally in ameliorating the former. Moreover, unless special care is taken, being sensitized to the pathogenic can leave one inadequately sensitized to stabilizing and maturity inducing factors.

4. *Reality factors.* Behavior is a function of the person and the environment. The personal factor encompasses the attitudes, feelings, abilities, and other attributes that can be ascribed to the individual. The environmental variable refers to events whose source is seen to lie outside the person. These events are referred to as reality factors especially when their frequency makes them commonly occurring events. Difficulties in employment, cultural attitudes and prejudices, conditions of the physical environment, are examples of reality factors with which a person with a disability must cope. The personal affective life of the patient cannot be ignored, but, unless rehabilitation is geared to coping with the many reality factors in the milieu in which the patient will live, treatment will take place in an environmental vacuum.

5. *Comprehensive treatment.* The many ramifications of adjustment to disability require attention to the individual's physical, emotional, and social problems, including economic matters and the nature of his interpersonal relations at home and in the wider community. The importance of "treating the person as a whole" becomes less of a cliché when it is realized that such areas are interdependent, improvement in one area often depending on improvement in the others.

6. *Variability of treatment.* Differences in the needs of persons with the same or a similar disability require variability in the over-all treatment plan, rather than the inflexible application of procedures to all cases grouped under the particular disability category. General laws of behavior and disease entities, however, are important in understanding the *special* characteristics of the individual and his needs.

7. *Participation of the patient.* Emphasis on the patient's assets and the attitude of acceptance of, and respect for, the patient are two of the most important factors that have contributed to the increasing recognition that the patient must assume, to the degree feasible, an active role in both the planning and executing of his rehabilitation program. Among the foremost consequences are the restoring, maintaining, and enhancing of the person's initiative and self-respect.

8. *Responsibility of society.* Effective living requires constructive effort not only of the person himself but also on the part of society. Society is obliged to establish schools, hospitals, recreational facilities, and work opportunities that will meet the needs of all its members. Where special needs are evident, special arrangements to accommodate them are indicated. Provisions for these can be made by the family, the local community, and the federal government. Government, as well as private and voluntary effort, shares the responsibility. Public education is the

responsibility of the local community and nation as a whole.

9. *Interdisciplinary and interagency integration.* The problems of disability cover practically all the problems that one might expect to encounter in human affairs. Consequently, their solution requires the coordinated effort of many professions, close working relations among the various kinds of rehabilitation agencies, and integration of available community resources within the program.

10. *Time dimension.* There is no point at which rehabilitation begins and other phases of treatment end. Rehabilitation is a continuing process that applies to the individual so long as he needs help and to society so long as conditions exist that interfere with the welfare of any group of its citizens.

11. *Ubiquity of psychological factors.* The human being reacts cognitively and emotionally to events that befall him. It is well known that these reactions in turn affect the course of those events. One is compelled, therefore, to recognize that psychological factors are ever-present and often crucial in all aspects of rehabilitation—medical, surgical, social, vocational, as well as psychological.

12. *Evaluation.* Because the process of rehabilitation is complex, it must be subject to constant re-examination. Its review must be checked against such principles as those suggested above, as well as against new knowledge and understanding derived from ongoing research. This applies to rehabilitation as it concerns the individual patient and action programs as a whole (Wright, *1959:26-28*).

Not all persons will accept these principles and assumptions. First of all, they reflect a philosophy of rehabilitation centering on the value of the human being, with his strengths and responsibilities, as well as on the role of society. They also bespeak a psychological viewpoint that others may not share. Because they have far-reaching implications, implications that give direction to rehabilitation and provide a test of our efforts on behalf of persons with disabilities, the principles and assumptions should be examined critically.

Psychological Factors in Rehabilitation

That psychological factors pervade the rehabilitation process (principle #11 above) is probably axiomatic to many specialists. Some, however, will contest the importance of such factors and some, though acknowledging them, will ignore them in practice. It therefore behooves us to scan a variety of aspects of rehabilitation that are undergoing change by the very fact that the role of psychological factors is being recognized.

1. *Psychosomatic medicine.* Psychological stress is increasingly being recognized as an important etiological factor in disease. Although some scientists question the separability of the concepts "psyche" and "soma," it is generally agreed that at the very least they are dynamically interdependent, each having consequences for the other. The maxim that one must not treat an organ but only a patient has a two-pronged significance, namely, that the emotional life of the person is important both as a cause in organic dysfunction and as a factor in coping with the problems that the dysfunction imposes.

2. *Preparation for surgery.* It is becoming increasingly accepted that the kind of information given to the patient prior to surgery has a marked effect on his emotional equilibrium after surgery (Janis, *1958*).

3. *The convalescent period.* The former notion that convalescence is a period of waiting for time and nature to complete healing is giving way to the view that, even before definitive medical care has ended, the patient should become involved in purposeful activity. The procedures of occupational therapy have been revamped accordingly. Avocational and vocational classes have been introduced during the convalescent period (Rusk and Taylor, *1946*).

4. *Vocational rehabilitation.* The modern point of view stresses the importance of introducing the services of vocational rehabilitation early in the patient's convalescence instead of allowing months and years of delay, an all too frequent pattern, to fix attitudes and reduce the work potential. The dozen principles and assumptions of rehabilitation have expanded the concept of vocational rehabilitation to include, in addition to the criterion of competitive employment, other productive goals, such as the sheltered workshop, homebound employment, homemaking, and the development of independent living. Increasingly, not only are the person's abilities being taken into account in vocational placement, but his interests and life habits as well.

5. *Workmen's compensation.* The present accident and liability insurance policies are being re-examined from the point of view of their effects on rehabilitation. All too commonly the monetary advantage to the injured party serves to encourage maximal disability and minimal recovery. Typically, the idea of medical care and rehabilitation is alien. A noteworthy exception is the present social security law, which requires that a worker's status be evaluated in terms of rehabilitation possibilities in case of disability. "Workmen's Restoration" as a concept to be substituted for "Workmen's Compensation" captures the new direction in thinking that has been prompted by the consideration of psychological factors.

6. *Hospital organization.* A "graduated care program" based on the needs of the individual patient is gaining acceptance as a means, both to cut down medical costs and to influence positively psychological factors important

in recovery. Instead of having everyone placed in the highly dependent position of an acutely ill patient, different levels of self-care are available. Those who are able to bathe themselves or eat in the cafeteria are encouraged to do so, for example.

7. *Homes for the chronically ill and aged.* "Not only must we add years to life, but also life to years" signifies the direction of change in the nature and function of such homes. *A meaningful existence*—this has a psychological referent par excellence.

8. *Prosthetic appliances.* More attention is being given to the fact that the attitudes of a patient toward his disability and toward the particular appliance are as important as engineering features in determining the use he will make of his prosthesis. In some centers the patient helps choose the prosthesis and is given training in using it in a wide variety of concrete situations that he will confront in daily life. An important part of this training is the encouragement of constructive attitudes toward his disability and prosthesis.

9. *Education of the public.* The fact that a person's acceptance of his disability and management of it is significantly influenced by the attitudes of others means that rehabilitation must include the family and the broader society within its educational program. This recognition has shown increasing involvement of parents, wives, and husbands in the rehabilitation plan. It has also drawn attention to the role of the public school in teaching children to look upon disability in terms of coping possibilities rather than as an overwhelming misfortune.

These nine examples, selected because of their diversity, are but a small sample of the many facets of rehabilitation in which psychological factors form an important part of the base upon which procedures are built. Yet, we are only beginning to "know" some things, and these "things" are woefully few in the light of the understanding required to produce a fuller yield from our rehabilitation efforts.

Consider the matter of motivation of the patient. Rehabilitation failures have focused attention on the patient who resists rehabilitation opportunities available to him. There is already sufficient evidence to point up the significance of the nature of the relationship between the rehabilitation specialist and patient, premorbid personality factors in the patient, and realities of the broader environment (Wright, *1960*). But much more needs to be known, particularly in regard to how to change existing conditions so as to bring about the desired change.

Although we need to know more about more, if the knowledge that has already been accumulated were applied effectively, tremendous progress in the rehabilitation field could be made at the present time. The nine examples mentioned above would be examples of typical practice instead of features of only our most advanced programs.

Myths and the Challenge of Research

To an enormous degree myths continue to take the place of sound knowledge. Specialists, for example, still think in terms of "the epileptic personality" when the range of personality characteristics of those with epilepsy coincides with that of unselected groups. We still hear that those who are deaf are prone to be rigid and suspicious and that maladjustment abounds among the disabled. Such assertions, and thousands of others, are products of lack of information, misinformation, prejudices, and certain perceptual factors that lead one to overgeneralize from "sometimes" to "always."

This latter factor is so widespread, so potent, yet so rarely mentioned, that it behooves us to examine it further. Two kinds of overgeneralization may be distinguished, namely, *subject* overgeneralization and *behavior* overgeneralization. In the former case, a characteristic that distinguishes two groups, however slightly, tends to be made typical of the group in question. For example, if the average score of a group of subjects with crippling conditions is below the norms on a personality test, then the tendency will be to regard the group as a whole as maladjusted even though a large portion may have shown better than average adjustment. A different example of subject overgeneralization is evident when facts that describe a particular sample of subjects are generalized to a wider population of which it is hardly representative. Thus, the behavior of children with a particular disability who attend a residential school is sometimes erroneously held typical of children with that disability living at home.

Behavior overgeneralization occurs when behavior that has been observed in a particular situation is misperceived as being typical of the person regardless of the nature of the situation. One common myth holds, for example, that children who are deaf are more rigid (less responsive to new requirements in situations) than are hearing children. The myth is corrected by the challenge of "It depends." In a series of experiments involving a *variety* of situations (Johnson, *1954*), it was found that "Deaf children are *not necessarily* more rigid than hearing children.... Deaf children may sometimes, in some situations, behave less rigidly than hearing children" *(p. 71)*. The experimenter speculated, on the basis of the situations studied, that the deaf will be flexible in many situations that involve acute visual perception.

Overgeneralization of both sorts is facilitated by the "halo" or "spread" phenomenon. Briefly, this means that, where a dominant characteristic of a person is negative, he will tend to be perceived negatively with respect to other characteristics as well, a parallel proposition holding for positive characteristics. For example, when deafness, a negative condition, is in the focus of attention, other negative characteristics, such as rigidity, easily be-

come perceived as possible concomitants. The merest rationale will tend to give certainty to the possibility. Signs of flexibility, on the other hand, tend to be ignored by the casual onlooker because these are incompatible with the halo phenomenon. The assumption of the compatibility of traits or entities of "like sign" is an integral part of Heider's theory of balanced states (Heider, *1958*) and of Dembo's studies of devaluation (Dembo, *1953;* Dembo *et al., 1956*), both of whose work have major implications concerning attitudes toward disability.

An additional factor in the tendency to overgeneralize may be called cognitive simplification. The fact is that it is easier to think and speak in terms of generalities, for in so doing we give a stability to the mass of variations in behavior with which we are confronted. How much more complex it is to think of the deaf as being both rigid and flexible *depending on the conditions,* than to resort to a stereotype! The former requires taking into account many variables, the latter only that of deafness.

There is also the role played by personal needs or prejudices in overgeneralization. For example, when there is a need to ensure one's own status by depreciating that of another, the able-bodied person will accent all the evidence that points to the unfortunate lot of the person with a disability and will repress contrary evidence. He will overgeneralize (by way of subjects and behavior) the presumed inferiority, tragedy, and rejection of the person with a disability.

The three sources of the overgeneralizing tendency singled out here for mention, namely, halo phenomenon, cognitive simplification, and personal need, are so potent that only with the aid of the objective and systematic approach of science can we hope to begin to restrict overgeneralizations, become aware of the myths, and replace them with facts and understanding.

The importance of psychological factors in rehabilitation, the scarcity of our knowledge, and the insidious power of myths to nullify the little that is known led the Institute on the role of psychology in rehabilitation to emphasize research in the training and functions of psychologists who reach the doctoral level. Although practical demands and varied interests preclude all psychologists from carrying out research as their primary function, it was affirmed that the doctoral candidate should attain a high level of sophistication concerning scientific inference, research methodology, and psychological theory. The fact that, in a recent sampling of reports submitted by the Veterans Administration Department of Medicine and Surgery to the Bio-Sciences Information Exchange, Smithsonian Institution, over 30 percent of the research was reported by psychologists (Houtchens, *1957*) was gratifying to the Institute, yet the participants were sufficiently humble to recognize that quantity is an inadequate measure of quality.

The Institute's insistence that research, more research, and better research holds high priority is also reflected in the more than 150 topics for study that appear in the appendix of the proceedings (Wright, *1959*). The emphasis on research also claims the final principle, among the "basic dozen," of rehabilitation *(see p. 3)*. It was tied to the belief that research on problems faced by a person with a disability produces both information about the disabled and basic psychological knowledge and theory.

Yet another conclusion emerges from the points considered thus far. If it is true that psychological factors are vital to the rehabilitation outcome, and, if it is true that knowledge is continually being threatened by myths, then it seems imperative that psychologists, during their formal training, should be enabled to examine the area referred to as "psychological aspects of disability," an area that can be conceptualized in two parts. One part, somatopsychology, is concerned with the way the person copes with the social connotations and personal meanings of his physique. Factors within the person and factors within the environment that hamper and facilitate constructive effort come within its purview. A second part, the psychosomatic relation, deals with the mental and emotional characteristics of a person that predispose him toward certain types of organic dysfunction. It may be added that, since psychological aspects of disability comprise an area that pertains to persons of all ages, and since its study offers a rich yield of hypotheses significant to general problems as well as those relevant to physique and disability, it would seem desirable that all psychologists, even those who will not enter the field of rehabilitation as such, have some familiarity with it.

One must further argue that all specialists working in rehabilitation—the occupational, physical, and speech therapists, the psychologist and social worker, the doctor and nurse—all must study critically the theories and facts of the somatopsychological and psychosomatic relations. To be sure, the content will vary according to the specialty. Sometimes existing courses could absorb the material; sometimes the addition of new courses will be required.

That a substantial part of the content must necessarily be devoted to debunking myths may be disturbing, especially when it is realized that not only are common sense notions connecting physique and personality often filled with misconceptions, but much of the scientific literature becomes untenable upon critical examination and research replication. Scorn for psychology on this score should be abated by the recognition that difficulties in verifying conclusions through duplication of findings also bedevil the hardheaded physicist and chemist. After all, an important characteristic of science is its approach, which allows its store of knowledge to be in a continual state of correction. Facts are true only until further notice. It is in the critical examination of the facts that myths become undermined and vision becomes broadened.

The Matter of Specialization

It might seem that the best way to guarantee that a psychologist working in rehabilitation will receive the training most adequate to the job requirements would be to establish a separate specialty. Certification by the American Board of Examiners in Professional Psychology already recognizes specialties in clinical, counseling, and industrial psychology. In addition, there are several other areas that are recognized by specialized training programs in graduate schools. There were several considerations, however, that led the Institute to veto the establishment of "rehabilitation psychology" as a new specialty at the present time, although psychologists in this field may still refer to themselves as "rehabilitation psychologists."

In a certain sense, a psychologist working in rehabilitation can best be identified by the principles and assumptions that give to rehabilitation its special cast *(see p. 3)*. Thus, a clinical or counseling psychologist who is so oriented can be said to be working in the field of rehabilitation. Instead of creating a new specialty, one might rather encourage the spread of the rehabilitation point of view to existing branches of psychology. Moreover, the reminder that "a specialist is in danger of becoming a person who knows more and more about less and less until he ends up knowing everything about nothing" serves to check the tendency to proliferate specialties.

This narrowing through specialization was felt to be true of some psychologists who maintain a "consultation room outlook," an approach in which diagnosis and counseling take place largely in an environmental vacuum bounded by the walls of the specialist's office and that excludes the situations and stresses that the rehabilitant faces in his realistic social milieu. If principle #4 underlying rehabilitation, referring to reality factors, is taken seriously *(p. 3)*, then the kind of specialization that leads to a confining of the functions of the psychologist to his consultation room must give way to a widening in which he becomes intimately familiar with the world of work, family, and community in which the client must function.

This does not mean making a social worker of the psychologist, but it does mean that his specialization cannot be so narrow in training and function that he knows little of these reality areas and cares less. On the contrary, broadening his horizons will enable him more effectively to co-ordinate his efforts with other professions and with other services available in the community. The unfortunate effects of overspecialization are also clearly evident in the case of the physician who regards rehabilitation as something outside the province of his profession. Respect for the family doctor is increasing just because he is not so highly specialized that he confines himself to disease entities and ignores problems of normal living.

Concern with the narrowing effects of specialization fell in line with the conviction expressed at the Institute that a psychologist working in rehabilitation needs deep understanding of the general laws of human behavior—those pertaining to man's growth and development; the way he learns about his world and how he copes with difficulties; his feelings of love, despair, shame, withdrawal, and many other "social emotions"; the significance of interpersonal relations, of the self-concept, and of environmental influences.

Study of such generally relevant psychological material, in its vastness and complexity, should consume much of the formal doctoral academic preparation and should provide a firm base upon which more specialized knowledge and skills pertaining to particular disability categories could be acquired. Although the emphasis is on general psychological preparation, some specialized course work is not precluded within the four-year doctoral program. Practicum experience in diagnostic and treatment centers and provision for on-the-job training are other means well suited to the acquisition of specialized knowledge and skills so long as sound grounding in the basic science of psychology has been achieved. Such a base, moreover, was felt to enable the psychologist more effectively to keep abreast of the many developments that succeeding years bring and to acquire specialized knowledge and skills appropriate to particular jobs, a variety of which he can be expected to fill during his lifetime.

Interprofessional Relations

Interdisciplinary integration is so vital to the nature of rehabilitation that it was made explicit in the statement of underlying principles *(#9, p. 4)*. Close working relations among the professions, however, create difficulties, especially when the professional goals and aspirations of its members are in conflict.

A detailed study of the role relations among psychiatry, clinical psychology, and psychiatric social work, has been reported by Zander, Cohen, and Stotland *(1957)*. It was found that psychiatrists and social workers have relatively amicable relations because their role aspirations are largely in harmony. Even though the average psychiatric social worker appears to have an ambition to increase the variety of her professional services, she wishes to continue to perform them under the supervision of psychiatrists. Since the psychiatrist aspires to make more effective use of the assistance provided by ancillary workers so that he can increase the value of his own services, he does not resist expanding the contributions of the social worker so long as he remains in control.

The relations between the clinical psychologist and the psychiatrist, however, are complicated by the fact that the average clinical psychologist not only desires to increase the usefulness of his profession by engaging in diagnosis and therapy as well as psychometrics and

research, but wishes to carry out these functions independently of the supervision of psychiatrists, though he is ready to join in a co-operative team relationship. Thus, the social worker is willing to meet her needs within her usual role relationship as psychiatric assistant, whereas the psychologist is more likely to seek autonomy. The fact that the psychologist and the psychiatrist value each other's profession, however, should provide a firm basis for improving relations and developing productive contacts.

The Institute gave special attention to the question of overlap in functions among the professions. Presumably, if the duties of the psychologist were sharply differentiated from those of other professions, the opportunity for conflict would be minimized. As noted in an earlier conference (Raimy, *1950*), a marked overlap of the clinical functions of the psychologist, psychiatrist, and social worker is typical:

> One of the most interesting paradoxes of the present field of mental health lies in the fact that, although psychiatry, psychiatric social work, and clinical psychology represent three quite separate fields as regards tradition and training procedures, their actual clinical functions often show marked overlap and their actual work in their routine activities in many clinics seems to be distinguished only by almost secondary functions of medical examination, case-history taking, and diagnostic testing. *(p. 150)*

Reducing the opportunity for conflict by reducing overlap in functions was felt to be shortsighted, however, for the functions of different professions cannot be arbitrarily confined. They develop according to the training and competence of the professional person, the meaningful exercise of functions, and the needs of society. Reducing overlap may mean further fragmentation of services to the patient, the unwholesome effects of which are most incisively pointed out in the following questions: ". . . in dividing his [the patient's] treatment into special areas, are we really using professional staff to the best advantage? Are they not, too, limited in their effectiveness by the very virtue of their specialization? Do they not also have more to offer than their particular skills?" (Stearns, *1956:4*) Parenthetically, it may be urged that the solution of jurisdictional disputes within a single profession should also give serious attention to the negative effects of *rigidly confining* areas of operation within particular specialties. A lively account of this problem as its exists among the many specialties of the medical profession has recently appeared (Croatman and Barland, *1960*).

Good interprofessional relations, as proposed at the Institute, should be strengthened, not by reducing overlap in functions as such but rather by (1) clarification of meaningful exercise of competencies and (2) greater maturity in team functioning.

An essential purpose of the Institute was to contribute to the first of these, and progress was made by examining and suggesting improvements concerning the education and training of psychologists who will enter the rehabilitation field. A second aspect of the problem of clarification of competencies was brought out when the Institute emphasized the responsibility of psychologists, as well as other professionals, to keep all personnel informed of their services in the particular settings in which they work.

It is of interest to report the findings of an interprofessional questionnaire that had been distributed in preparation for the Institute to approximately 250 specialists representing eight different professions (occupational therapists, physical therapists, physicians, psychiatrists, psychologists, rehabilitation center directors, rehabilitation counselors, and social workers). All professional groups other than physicians and rehabilitation center directors, who were divided in their opinion, clearly indicated that the psychologist seemed to have as clear a notion of his role as other professionals. Moreover, all professional groups other than social workers, who were somewhat ambivalent, believed that the psychologist did not overstep his bounds of competency more than did members of other professions.

Some attention was given to the matter of maturity of team functioning. The interprofessional questionnaire revealed that, except for physicians and psychiatrists, who were divided in their opinion, the respondents felt that the team leader should not routinely be represented by the same profession and should rather be selected on the basis of (1) the nature of the problem presented by the particular patient or client and (2) the personality of the professional person.

Closely aligned to the first is the fact that the type of agency or setting often determines the team "captain." In medical settings it is typically the physician; in guidance clinics there is more flexibility, and the psychologist or social worker sometimes is in charge of particular cases; in school settings, the administrator or special teacher may assume responsibility for guiding and integrating the team relations; in state divisions of vocational rehabilitation, it is the rehabilitation counselor who frequently fulfills this role.

The second criterion clearly hinges on the nature of group functioning sought. The report of the Institute pointed out that—

> An autocratic leader, irrespective of his professional identification, might function well in a setting that wishes to maintain hierarchial prestige levels among the professions. He might function well where other services are regarded as extensions of his arms, legs, and intelligence, as executors of his directives, as resources for information, but not as equals in a common goal of serving the patient. A democratic leader, on the other hand, would fit the role connoted by the term "team chairman." In this capacity, he might still be "in charge" of the case, but the decisions

would more clearly be a product of the group. Though certain of the decisions connected with the team chairman's discipline might ultimately be his to make (together with the client), those outside his sphere would be delegated to other specialists (Wright, *1959:74-75*).

Spurious team functioning that fosters assembly-line treatment in which several specialists see the patient in turn and file reports in the case folder without ever considering the findings as a whole was singled out as all too typical. The opinion was vigorous that the several disciplines must work together with the client as a joint staff in planning and evaluating rehabilitation efforts if the rehabilitation process is to achieve its highest potential of meeting the needs of the client in all his interrelated purposes and functions. This cannot be done in an offhand manner but requires definite arrangement within the agency's operative structure.

Power and status drives are especially strong motivators and, unless held in check and channeled by the philosophy of rehabilitation and the needs of the patient, lead to a jealous guarding of assumed professional prerogatives rather than a readiness to utilize the competencies of all specialists to their fullest measure. On the basis of knowledge of group dynamics and their study of role relations in the mental health professions, Zander, Cohen and Stotland *(1957)* believe that it is possible to reduce the insecurity and conflict among professions by having the members identify the sources of difficulties and, in an atmosphere geared to taking mutual needs into account, re-evaluate professional goals and functions:

All groups concerned can develop and agree upon a common set of goals. Thus, the efforts of any separate group toward the goals will be considered to gratify the needs of the rest, which is, after all, the essence of the co-operative relationship. Sometimes functions and role responsibilities can be so arranged that the interactions of persons with those in different professions will satisfy mutual needs. At other times functions can be assigned so that they provide autonomy in certain areas for each individual. In certain cases procedures can be developed so that unsatisfactory relationships are identified and analyzed, and appropriate adjustments made. (Zander, Cohen, and Stotland, *1957:152*)

Not all difficulties among the professions can be avoided. It may even be true that not all difficulties should be avoided, for differences in orientation to the solution of problems faced by clients and faced by specialists may catalyze new thinking and study. Yet it certainly is true that, when the difficulties lead professions to avoid working together or to minimize the contributions of each other, a new effort to develop mutually satisfying relations oriented primarily toward the welfare of the client and not the profession must be made.

The Institute was an expression of society's need to enlist the knowledge and skills of psychology more fully in the service of rehabilitation. How effective the tie between psychology and rehabilitation will become depends, of course, on many factors. Among the most important is the fact that communities are increasingly accepting the responsibilities that go with rehabilitation as a point of view based on respect for the individual and a confidence that his life is worth something, that he will be able to contribute in one way or another to himself and society. Nonetheless, the importance of treating "the whole man," not in an environmental vacuum, but with full appreciation that life must be lived in a community of people and things, requires greater understanding of the concept of rehabilitation on the part of the professional person and the community as a whole.

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Review of the Month

The Slow Learner In the Classroom

By Newell C. Kephart, Ph.D.

Published by Charles E. Merrill Books, Inc., 1300 Alum Creek Dr., Columbus 16, Ohio. 1960. 292 p. illus., figs., tabs. $4.95.

Reviewed by G. Orville Johnson, Ed.D.

THE EDUCATION of the slow learner is rapidly coming to the forefront as one of our most acute educational problems. Often ignored in the past, during the last decade it has caused more heat to be generated and words spoken than during the preceding century. Books, pamphlets, and other materials on the subject are purchased as soon as published and avidly read. If they quickly vanish from the market, it is due to lack of contribution rather than lack of interest. Teachers and administrators are continually writing letters of inquiry to "authorities" requesting aid and assistance in planning programs for the slow learner. In addition, conferences and workshops focusing on this problem are more and more in evidence.

This desire for aid on the part of teachers and administrators and general activity by educators have left the major problems still unsolved. Of prime importance are a definition of the slow learner, a good definition upon which to base sound curriculum development, and a description of any special technics or methods that are uniquely applicable to this group. The first point has been particularly confusing because the term *slow learner* has meant various things to various people. To the educator it has meant essentially that 15 to 17 percent of the school population have not been able to perform academically at their otherwise appropriate level because of limited intellectual abilities. To others the term has referred to the mentally handicapped (educable), those needing remedial teaching, and the lazy, disinterested student.

Well-written, scientifically based articles and books concerned with the slow learner are almost nonexistent. After reading the introductory paragraph of the preface to *The Slow Learner in the Classroom,* the educator, I am sure, like the reviewer would have his hopes raised that here at last might be a volume of value. The author states, "This book is written for the classroom teacher who has a few pupils who never seem quite able to learn what others are learning readily and eagerly.

About the Author . . .

Dr. Kephart has been a professor in the psychology department of Purdue University since 1945. After earning his Ph.D. degree in child welfare at Iowa University in 1936, he was mental hygienist with the Wayne County (Mich.) Training School for five years, was affiliated with the U.S. Employment Service during 1941-1942, and served three years with the U.S. Navy. Dr. Kephart's special fields of interest are visual perception, the retarded child, and the brain-injured child. He is an industrial diplomate of the American Board of Examiners in Professional Psychology and a member of the American Psychological Society.

About the Reviewer . . .

Dr. Johnson, a professor of education at Syracuse University since 1954, received his Ed.D. degree from the University of Illinois in 1950, where he was assistant professor (1949-1951). He also was associate professor and director of special education and co-ordinator of clinical services, University of Denver (1951-1953) and directed the New York State Research Project on severely retarded children in 1954-1956. Dr. Johnson previously had spent a number of years as a public school teacher, psychological assistant with the Army Air Corps, and as a principal and psychologist at the Southern Wisconsin Colony and Training School. He is a member of the American Psychological Association, division of educational psychology, and a Fellow of the American Association on Mental Deficiency.

Teachers of special groups will also find the book valuable, since many problems of the special student are similar to those of the slow learner." Imagine the reviewer's disappointment when, after a careful perusal of the book, he was unable to find either a good definition of the "slow learner" or the "special student." As a result, the questions still remain. Who or what is a slow learner? What is the incidence of the problem? What unique curriculum, learning experiences, and technics (if any) must be provided so such students may derive optimum benefit from school?

The prospective consumer of *The Slow Learner in the Classroom* may possibly obtain the clearest picture of his investment by first briefly examining the contents of the volume. An overview of the major subdivisions may aid him in determining whether the volume will at least help meet his needs. Part 1 is entitled "Development and Achievement," in which such areas as motor skills, "motor bases of achievement," "the perceptual process," "development of form perception," and "space discrimination" are discussed. Since less than 100 pages are devoted to them, these quite complex ideas and theories are of necessity less adequately dealt with than in volumes mainly concerned with only one or a few of them. The related learning is obviously based upon theory originally propounded by Hebb and again described in greater detail elsewhere. Further, the reviewer questions the premise of paragraph one of the preface, that the typical classroom teacher will either thoroughly understand or benefit from this part of the author's discourse.

The second major division is devoted to "a perceptual survey rating scale" and the final section to "training activities." Here specific training related to chalk-board activities, sensorimotor, ocular control, and form perception is described in some detail. The methods and devices used are clever and clearly enough described to be easily followed and duplicated. The reviewer, however, was struck by the author's reinterpretation of relatively common readiness activities used by most good primary teachers as being uniquely necessary for his (defined?) group.

To put it mildly, the reviewer, by the time he had completed the volume, was rather thoroughly confused. Part of the confusion undoubtedly resulted from certain preconceptions concerning the "slow learner" brought with him to the reading and derived from the title. These preconceptions, however, were reinforced by the first paragraph of the preface, previously quoted. Other problems facing the reviewer were concerned with the author's basing assumptions upon theories under discussion and related to problems of learning, particularly concerning perception, that have as yet little foundation in fact or results of research. For example, "If the child's learning difficulties are related to a deficiency in perceptual motor readiness, it is necessary to identify the point at which the breakdown occurred" (p. 120). Although this statement is conditional, the context of the volume is largely written with the implication that it is true. Further, the relationship between perception (as used here) and learning certainly has not been established.

The most common referrals to other works made by the author are to *The Psychopathology and Education of the Brain-Injured Child,* Volumes I and II, written by Strauss and Lehtinen and Strauss and Kephart. The present volume appears to be an extension and somewhat more detailed description of certain aspects of these books. As such it belongs appropriately with them but not as an educational work concerned with the problems of the slow learner as the teacher and administrator define and conceive him.

Success Through Play by D. H. Radler with Newell C. Kephart is written with the same orientation as the volume reviewed above. This book is directed to parents preparing their preschool children for school and provides them with selected "play" activities. The activities described are mainly identical with those included in *The Slow Learner in the Classroom.* The criticisms of the two volumes are largely the same.

Success Through Play; How To Prepare Your Child for School Achievement—and Enjoy It

By: **D. H. Radler,** with **Newell C. Kephart;** foreword by Richard J. Apell, O.D.

1960. 140 p. illus. Harper and Bros., 49 E. 33rd St., New York 16, N.Y. $3.50.

Other Books Reviewed

1

The Neurological Examination of the Infant

By: **André-Thomas, Yves Chesni,** and **S. Saint-Anne Dargassies** (edited by R. C. MacKeith, P. E. Polani, and E. Clayton-Jones)

1960. 50 p. illus. Paperboard. Medical Advisory Committee, National Spastics Society, 28 Fitzroy Square, London, W. 1, England. 5s ($1.00) a copy.

THIS SMALL BOOK is the first of a series of five supplements planned and in the process of publication under the direction of the Medical Advisory Committee of the National Spastics Society. Routines for the neurological examination of the newborn or older infant, as developed by Drs. André-Thomas and St.-Anne Dargassies of Paris, are described briefly and illustrated extensively. In the foreword Drs. Polani and MacKeith discuss the segmental scheme of the examination, much of which depends

upon assessing "tone," mainly through observation of static postures and the effects of direct and indirect passive movements of the limbs when the child is alert but not crying. The editors recommend thorough understanding of the information presented in the foreword before reading explanations of the routines, since these are brief and contain underlying concepts unfamiliar to those with little or no knowledge of French neurological examination methods.

Future supplements and their contents will include: Introduction to Gesell, by Prof. R. S. Illingworth.—Landmarks in the definition and classification of cerebral palsy, by Paul E. Polani. Annotated bibliography of cerebral palsy, compiled by W. J. Bishop.—The contributions of animal behavior studies to paediatrics, by Anthony Barnett (and others).

2

Occupational Therapy in Rehabilitation; A Handbook for Occupational Therapists, Students, and Others Interested in This Aspect of Reablement

Edited by: **E. M. Macdonald,** B. Litt., T.M.A.O.T. (and others)

1960. 348 p. illus., figs., charts. Published by Bailliere, Tindall and Cox, 7 & 8 Henrietta St., London, W.C. 2, England, and available in the U.S. from The Williams & Wilkins Co., Baltimore 2, Md., at $8.50 a copy.

LORD AMULREE, a physician and a past president of the Association of Occupational Therapists in Great Britain, notes, in his foreword, the competence of the 19 contributors to this textbook written from the British point of view. Opening with a brief historical account of the development of occupational therapy, the book is intended to provide insight into the basic principles, philosophy, and purposes of treatment, the needs of patients as people, and the objectives of treatment in a wide range of physical or mental diseases and conditions. No attempt has been made to indicate specific activities for specific disabilities but various treatment media are discussed generally in Chapter II. The discussion of administrative aspects of the therapy program, record keeping, patient evaluation, and vocational rehabilitation should be useful to the therapist in treatment planning. A nine-page bibliography and two indexes are additional aids.

3

Outlook for the Adult Retarded; Proceedings of the 35th Spring Conference of the Woods Schools . . . Boston, May 6 and 7, 1960

By: **The Woods Schools,** Langhorne, Pa.

1960. 123 p. tabs. Paperbound.

CONTENTS: Public programs for the aging and their implications for retarded adults, Louis H. Ravin.—Developing patterns for aid to the aging retarded and their families, Gunnar Dybwad.—Massachusetts' programs for the mentally retarded, Foster Furcolo.—New York State Employment Service's experience in placing the mentally retarded, Janet I. Pinner.—On-the-job assistance, Max Dubrow.—Legislative support, Irene K. Thresher.—Guardianship plans for retarded children, Lee J. Marino.—Insurance, W. Scott Allan.—Standards of personal care and nutrition, Sister Mary George.—The changing population, Harry C. Storrs.—Mental health attitudes, Mesrop A. Tarumianz.—Medical care, Karl V. Quinn.—Programs for patients, Benedict Nagler.—Summary of Conference, Mortimer Garrison, Jr.

This year's Conference was held in co-operation with the Massachusetts Special Commission on Retarded Chil-

For Your Leisure-Time, Professional Reading

WHAT IS THE WORLD like to an eight-year-old boy suffering from schizophrenia? The author of this short novel is a practicing psychiatrist who has seen many severely disturbed children like Jordi. In *Jordi,* a composite case history, we enter into a private world where all persons are strangers, where inanimate objects are as much alive and threatening as people, and where love and hate cannot be experienced. Dr. Rubin conveys, through the eyes of Jordi, the boy's isolation even from his mother and father, whose patience and love cannot bridge the gap between his and their worlds. But Jordi is fortunate; he is sent to a special school where his teacher Sally, with patient insight, is slowly able to reach him. We see the episodes in the four and one-half years of the Jordi-Sally relationship that teach him to feel anger, to express his fears, and to find pleasure in normal childhood activities of play and learning. It takes but an hour to read this bit of fiction, but the reader will have passed from a world of darkness into light, just as Jordi did.—*The Editor.*

Jordi

By: **Theodore Isaac Rubin,** M.D.

1960. 73 p. The Macmillan Company, 60 Fifth Ave., New York 11, N.Y. $2.95.

dren at the Massachusetts Mental Health Center, Boston. Single copies of the Proceedings are available on request from the Publications Office, The Woods Schools, Langhorne, Pa. Additional copies, $1.00 each (less in quantity orders).

4

A Primer of Social Casework

By: **Elizabeth Nicholds**

1960. 181 p. Columbia University Press, 2960 Broadway, New York 27, N.Y. $4.50.

SOCIAL CASEWORK skills and technics are not learned in six easy lessons, Mrs. Nicholds is quick to point out. She believes, however, that the untrained worker or volunteer, the inexperienced caseworker on the job, or professional persons whose work often calls for the application of casework technics in dealing with people in need can read this book with profit. Simple, nontechnical language is used to explain the value of interviewing technics, how to recognize and deal with specific problems through effective referral to appropriate community resources, and how to promote good client-worker relationships in casework situations. The book could also be used effectively in stimulating interest in social work as a career or in orienting lay workers in the community agency. The following chapters may be of special interest: Chapt. 13, The Retarded Child; Chapt. 14, The Physically Handicapped; and Chapt. 17, The Aged. Includes an annotated bibliography of recommended readings (p. 159-175).

5

Proceedings of the ISRA Symposium on the Social Aspects of Chronic Rheumatic Joint Affections, Especially Rheumatoid Arthritis, Amsterdam, 13-14 October, 1959

By: **International Study Centre for Rheumatic Diseases, Amsterdam** (ed. by G. van Dam and W. Hijmans)

1960. 131 p. tabs. Paperbound. *(Excerpta Medica Internatl. Congress ser. no. 23)* Available in the U.S. from Excerpta Medica Foundation, New York Academy of Medicine Building, 2 E. 103rd St., New York 29, N.Y. $4.00.

THE SYMPOSIUM was organized in three sections dealing with new developments in population studies of frequency of rheumatoid arthritis, the significance of sociomedical factors in management and control of the disease, and the social and economic implications of rheumatoid arthritis for the individual and the community. Participating in the conference, from the United States, were Drs. R. W. Lamont-Havers, Currier McEwen, and R. H. Manheimer. Subjects of their papers were: Vocational rehabilitation of arthritis patients in metropolitan and suburban areas, R. H. Manheimer and J. G. Benton, p. 55—The development of the campaign against rheumatic diseases in the U.S.A., C. McEwen, p. 71.—Some aspects of the sociomedical organization for the care of the patients with rheumatoid arthritis in the United States, R. W. Lamont-Havers, p. 79.—Significance of rheumatoid arthritis to the social status of the patient, R. W. Lamont-Havers, p. 105.

6

Progressive Lessons for Language Retraining

By: **Frieda Decker** (illustrated by Veronica Karp)

1960. 4 vols. illus. Unbound. Looseleaf. Harper & Bros., 49 E. 33rd St., New York 16, N.Y. $1.50, each book.

PLANNED FOR USE by the speech therapist working with adults having expressive aphasia, these four workbooks contain lesson sheets illustrating real life situations familiar to the patient in his pretraumatic experience. Through skills of reading, writing, and arithmetic the patient's vocabulary is gradually built up in progressive stages. The numerous illustrations aid recall of vocabulary. Practice sheets for "homework" provide opportunity for review of material covered in the speech therapy session.

The set consists of unbound sheets in folders, each of which fits into an envelope of the same color. Titles of the separate books are: 1. *The Days at Home.*—2. *Mr. and Mrs. Day Go Shopping.*—3. *The Days Take a Trip.*—4. *The Days Buy a House.* Because the material is progressive in difficulty, it is possible to start the brain-damaged adult at his own level.

Miss Decker is an experienced speech therapist and has helped to organize speech clinics in the San Francisco Bay Area. On leave of absence from her work as Chief Speech Therapist at the California Rehabilitation Center, Vallejo, she is completing her doctorate at the University of California (Berkeley Campus).

7

Therapy Through Horticulture

By: **Donald P. Watson** and **Alice W. Burlingame**

1960. 134 p. illus. The Macmillan Co., 60 Fifth Ave., New York 11, N.Y. $4.95.

ALTHOUGH MRS. BURLINGAME has written and published several articles on horticultural therapy (see *Rehab. Lit.*, July, 1958, #767, and June, 1959, #493)

(Continued on page 29)

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.

9

Problems of Child Care in Prolonged Hospitalization

By: **Emma N. Plank** *(Assistant Professor of Child Development, Department of Pediatrics, School of Medicine, Western Reserve University, Cleveland 6, Ohio)*

In: *Child Welfare.* Nov., 1960. 39:9:23-26.

A CHILD'S ADJUSTMENT to illness and separation in a hospital is complicated by the traumatic experience of some hospital procedures, whether he is subjected to them or merely observes them. A long hospitalization intensifies the problem, as does the need to stay on because of home problems when the child is ready for discharge.

In the department of pediatrics and contagious diseases at Cleveland Metropolitan General Hospital, where I direct the Child Life and Education Program, the *child care worker* is the member of the clinical team responsible for the children at play or in the hospital school and at meal time, but not actually involved in nursing functions. She may help prepare the child for medical procedures through dramatic play or earnest conversation in the playroom. The whole clinical team decides on the living patterns of the children in the different wards. The task of the child care worker depends on a team that works spontaneously and passes on information quickly and informally.

Beneficial effects of intensive casework with parents, visits of siblings, and home visits of the patient have been discussed elsewhere. If the family cannot give basic emotional support, the clinical team must take on this task.

The child care worker focuses on the child rather than the sickness. She must understand the illness, the child's reaction, and his defenses against his reaction. She must learn to recognize and develop the child's ego so she can help him deal with the often grim reality. Children on the ward behave differently from other children, and she must modify her concepts and technics. The common denominator at the hospital is neither age nor sex, nor the sociocultural background: It is the anxious uncertainty in a treatment situation. Older children can function as protectors or playmates for the younger, while the helplessness of the very young and delight in seeing developmental changes in a young child can act as a morale builder for children from age 3 up. Through empathy children can reduce their denial of the illness to a more wholesome level. The age range on a ward should be wider than usual.

Empathy as Defense Against Anxiety

Howard, age 10, and Frank, 4½ years, both with tuberculous meningitis, shared an isolation room for about 2 months. Frank's parents could visit him rarely. Comatose about 4 weeks, Frank was semicomatose when Howard was admitted. Any attempt to touch him brought piercing screams. Howard, on the other side of a glass partition, was completely inactive, just beginning to look at television for short periods.

During one of my visits Frank screamed when his linen was changed. Howard called to the nurse, "If you cover him up, he'll stop screaming," and true enough he stopped. Next time I asked Howard how they were, he said, "If I tell Frank to look at TV he'll look." The little boy, otherwise completely rigid, did so.

When Howard was transferred to the convalescent unit, we decided to move Frank also, even though he had only partially recovered his vision and was completely immobile. We feared a setback if he lost his only friend and protector. Howard was told he could get up now and join other children at play. The two shared a sleeping room and Howard would stop by for an occasional meal or play. Both did well after Howard's discharge. Frank left 2 months later, having formed strong relationships with several adults and learned to talk and play again.

The strong bond between the two did not spring from altruism. Produced by Howard's anxiety, it was most helpful to both. Howard was a Negro and Frank a Eurasian.

Kathy, 7, had been hospitalized for almost 2 years with most severe paralytic poliomyelitis and marked respiratory deficiency. Charming and lively, she was encased in braces and machinery, had a tracheotomy, and was in constant need of respiratory aid. Roger, 8, new on the ward, had paralyzed legs and was bedbound. He had been anxious prior to his illness. In the ward, with its many incomprehensible gadgets, he found an outlet for his now almost unbearable anxiety. He asked that his bed be moved close to Kathy; he fed her and spent most of his time next to her for 2 weeks. His anxiety was temporarily relieved.

Roger's and Howard's cases were similar—the close give-and-take with a sicker child helps them hold their anxiety and their own illnesses in check. Their IQ's were below average, but they had amazing intuitive insight and power of observation.

Counteracting Regressive Tendencies

Children who undergo serious body changes and are severely restrained in their motility through illness develop a distorted image of their body and its functions. Unable to independently do things such as eat or eliminate, they are at times thrown back into pre-oedipal phase feelings. We find it important to use all available substitutes to allow children to function on their proper developmental level. They have some choice in their family-style meals. They may visit the hospital kitchen or have some foods prepared on their ward or are taken on picnics. They are encouraged to assist in their baths, particularly to wash their own genitals. A mirror is hung in the tub room so those completely paralyzed can see for themselves that the damage to muscle functioning does not distort the rest of the body.

Bedbound children can observe very sharply; this can be used in a creative approach to learning. Vital participation in the learning process can represent a link between the *before* and *after* of a hospital stay. It can reassure the child that his thinking was not damaged and that the hospital, his own school, and his parents are planning for a future. Learning must challenge and satisfy, not be rote. The term *diversional activities* is unfortunate as it is a static concept and not dynamic. In his daily life, a child needs to participate with all available emotional and intellectual energy.

Mark, a 12-year-old with severe paralytic poliomyelitis and respiratory deficiency, started his school work 2 weeks after the onset of illness, while in the iron lung. We started with his main interest science. Plumbers and electricians gathered old faucets and appliances to be disassembled. We collected insects, including a pair of live praying mantises. From a nest of mantis eggs hundreds of nymphs hatched. Mark tape recorded book reviews and reports to send his home school.

After about a year in the hospital, he could sit up an hour daily. On his way to the school room he always tried to look in the doctors' laboratory. With the equipment he studied micro-organisms from his aquarium. He could not use his hands, but the teacher demonstrated how to stain slides and he could see them with a microscope. The doctors saved him slides of disease-causing bacteria. Questions about diagnosis and disease were sometimes answered by trips to the virus research department and bacteriology laboratory. A high school science club held meetings at the hospital so Mark could join in.

Children Awaiting Placement

Ego-threatening problems arise when children must stay in the hospital beyond medical need. Good foster homes for young children after hospitalization for tuberculosis are difficult to find. The child care worker in the convalescent tuberculous service unit functions like a nursery school teacher, using equipment and materials as well as relationships to give these children a chance to develop in all areas.

The family constellation often changes while the children are away—families move, new babies are born, or a parent leaves home because of illness or for other reasons. A new baby must seem to the hospitalized child like a substitute for himself, who is "no good anymore." Three-year-old Johnny was a patient for 18 months, during which he saw his mother about twice. He saw his new little sister on a visit home. As he was convinced that, if he were only a girl, his mother would take him home to stay, he wanted for two days to be dressed like a girl. He was allowed only to choose his shirt and pants. After his favorite adult assured him she liked little boys, Johnny particularly, he could give up pretending to be a girl and resumed his identity.

The child care worker must deal with a wide range of problems. She must know how to function as a member of the clinical team and be capable of facing emotionally exhausting situations. She plays different roles with different children or situations. We believe the child care worker can come from any of the three obvious professions—nursing, education, or social work. Most important is identification with the job, to help the child through the ordeal with as little adverse effect as possible. The educator (grade or nursery school teacher) has an advantage. Both children and parents can relate her to persons with a role in outside life. In contrast to figures "connected to the hospital," the educator can be a figure "connected with health." She can and should become a symbol of the child's future.

Child Welfare is published monthly except August and September by the Child Welfare League of America, 345 E. 46th St., New York 17, N.Y.; subscription, annual $4.00, three-year $10.00, 45¢ a copy; student rates, annual $2.75, two-year $5.00.

10

Hypnosis, an Adjunct in the Treatment of Neuromuscular Disease

By: **Richard F. Baer**, M.D. *(1213 Elco Dr., Maumee, Ohio)*

In: *Arch. Phys. Med. and Rehab.* Nov., 1960. 41:11: 514-515.

HYPNOTHERAPY CAN AID the physiatrist, for over half the patients able to benefit can develop the desired trance state. In arachnoiditis, dermatomyositis, arthritis, burns, paraplegia, and neoplasms, pain can be alleviated or eliminated by posthypnotic suggestion for hours or weeks. Trance relaxes a patient so he may have tightened muscles stretched with little or no pain. Appropriate verbalization dispels post-treatment discomfort or fear of further treatment. In pain control it is surmised afferent impulses are blocked at the thalamic level, preventing spread to the cortex. Recordings of the treatment

session played at home can reinforce suggestions. Posthypnotic suggestion can control spasticity in case of partially injured or diseased cord. The control, believed in the midbrain, suppresses afferent impulses and more active inhibition of existing lower motor neuron activity.

In syringomelia and multiple sclerosis, I believe the bladder is controlled by damping the afferent flow of impulses from the bladder and modifying the efferent flow ordinarily producing involuntary bladder contraction and incontinence. (Apparently this mechanism also controls double vision in multiple sclerosis.) A patient is asked in trance to remember urinating previous to symptoms and a posthypnotic suggestion for maintaining continence is given. The author has had no success in teaching this bladder control to males, as the external sphincter is too well developed and controlled and does not relax enough with suggestion. In women the external sphincter is poorly developed; a good subject can develop her own trance and remember bladder contraction or relaxation. Eventually merely sitting on the stool results in bladder or bowel emptying. The duodenal-colic reflex is used in teaching bowel control in paraplegia of L-4 or below. Voluntary centers of defecation are impaired but some autonomic function remains, available in the trance state. The patient induces the trance state, abreacts the experience of defecation, and elimination follows, produced apparently by increased activity of the colon.

Athetoid movements of mild cerebral palsy can be greatly minimized or eliminated, resulting in improved speech and all voluntary functions. Patients learn to develop the trance state and use the autosuggestion of relaxation, an aid in performing at highest capability, particularly in a tension situation. Cues are used to reinforce suggestion. After conditioning, relaxation is effortless. Aberrent activity of the extrapyramidal system appears dampened in some way.

Hypnotic suggestion is highly successful in phantom limb or in accustoming a patient to new dentures or a prosthesis. Habit patterns are quickly learned and altered with suggestion. Movement patterns can soon become habit patterns. Hypnotism can reverse malnutrition secondary to burns or disease through suggestion of hunger and can be used to increase fluid intake, decreasing renal complications in the cord-injured.

Results of use of this modality depends on the individual skill and judgment of the practitioner. Learning the technic may be time-consuming and its use cumbersome. With experience, time considerations are less of a problem due to better selection of subjects and various short cuts.

The Archives of Physical Medicine and Rehabilitation is published monthly at 30 N. Michigan Ave., Chicago 2, Ill.; annual subscription rates: United States and Mexico $8.50, Canada $9.50, elsewhere $14.00; $1.00 per single copy, $1.50 special issues.

11

Objectives and Characteristics of Graduate Education

By: **W. G. Hutchinson, Ph.D.** *(Dean, School of Allied Medical Professions, University of Pennsylvania, Philadelphia 4, Pa.)*

In: *Phys. Therapy Rev.* Oct., 1960. 40:10:733-736.

TO FACILITATE our discussion graduate education must be considered as a program leading to scholarly degrees or one leading to professional degrees. In a program leading to the master's or doctor of philosophy degree, where depth is emphasized, the objectives are to promote research and train new scholars and teachers. For a professional degree, the objective should be high-level training in a professional specialty, such as physical therapy, for those having bachelor's degrees in liberal arts or sciences. A master's degree should be in one category or the other—an institution should not award master's degrees in both the scholarly and professional categories since they appear mutually exclusive.

Graduate education must challenge and demand all the student's ability. The student should have the opportunity to experience the inner warmth that comes from accomplishment.

Research. One excellent way of learning is to demonstrate by one's own research the fallacy of what one has been taught; the other way is to teach. A graduate program must be intimately related to research. A certain impetus and enthusiasm is gained only by one's efforts to push back the barriers of ignorance. I question the dignifying by the term research the preparation of surveys based upon questionnaires or interviews. Research in physical therapy should have as its goal clarifying the effects of procedures involved and thus remove commonly employed procedures from the realm of empiricism. At present the therapist, rarely equipped for such research by himself, can be very effective on a research team comprised perhaps of a physiologist, a physician, a biochemist, and those from other related fields. I feel strongly that every graduate student should also do some teaching—on the level of an assistant to a faculty member, possibly laboratory instruction or participation in discussion or conference groups.

Selection of Students. Good graduate education depends on a well-equipped staff and a high level of student. Today, with few exceptions, motivation for graduate education necessarily derives from the desire for the individual's own social and economic betterment. The basis for selection is a perennial question. Graduate record examination has been found ineffective, but there seems to be no better device. It is generally believed that a student with less than a B average in undergraduate courses pertinent to his field of interest in graduate work would be very much of a risk. Ideally the student should

have the prerequisites demanded for admission to a program. In the sciences, a student rarely has no such deficiency. These prerequisites could be made up on an undergraduate basis with no graduate credit given.

Examinations. There is a growing tendency to liberalize semester credit requirements and to demand instead a certain level of knowledge. For an advanced scholarly degree the preparation of a thesis based on the original investigation of the student (supervised by a staff member or, better, a committee) should be essential. A comprehensive examination should be given in addition to or in lieu of course examinations. I have found the oral examination far superior to the written, for the staff may extend the breadth and depth of probing.

Part-Time Study. Many persons have little opportunity to carry on graduate work on any basis other than part time. If at least one full academic year is not spent in residence the student loses the intimate contact with other students and staff members, one of the most important contributions the school can make to the advanced training of the individual.

Changing Trend. In leading American universities the trend is away from undergraduate professional degree programs. Quite likely, present programs in physical therapy leading to a bachelor's degree may be replaced by a master's program available to those who already hold a bachelor's degree with certain prerequisites, eliminating the certificate course. If this change does come, I feel it will be very slow in developing, but this must color our thinking.

Scholarly Programs. If physical therapy continues as an undergraduate major, graduate training in physical therapy per se could be limited to the master's degree program, available only to graduates of such undergraduate programs. If, however, professional training in physical therapy ultimately becomes entirely a graduate program, further graduate work in depth must be through scholarly programs leading to the doctor of philosophy degree.

We should ask ourselves questions: What is physical therapy? Of what should education in this area consist? Is it simply an educational program adapted to the acquiring of skill in technics? If so, it belongs only in trade schools or in hospital teaching programs. If it is more, and I am sure it is, of what does it consist? Let me suggest it is an educational discipline that has evolved from the use of special technics but now encompasses fundamental theory from several areas of the basic sciences. Does this mean physical therapy cannot stand on its own feet as an educational discipline but is destined to depend on some prosthetic device fashioned from other branches of learning?

Gradual Development. My view is that a body of knowledge is being accumulated in physiology, anatomy, neurology, and other areas specifically relevant to the approach of the physical therapist. This knowledge will gradually become the scholarly data of physical therapy, so necessary as the foundation for an area of advanced learning. Graduate work in physical therapy leading to advanced scholarly degrees should await the accumulation of enough such data. Physical therapists who have or are working toward advanced and scholarly degrees in areas closely related to physical therapy, such as physiology and anatomy, should be responsible for the accumulation of such data.

Physical Therapy in Universities. As work in each science was introduced into the graduate level, the new field took its place at the bottom of the "pecking order," with those in the other graduate fields criticizing its inclusion. I am concerned that there be an abundance of evidence to refute any suggestion that physical therapy is not of the calibre or stature to warrant work on the graduate level. Self-interest should be abandoned and present graduate programs in physical therapy and allied medical fields should be examined frankly. Let us avoid the assumption that a graduate program in progress is necessarily a good one.

With few exceptions the fields within the medical area can be regarded as applied biology. To establish a sound foundation any graduate endeavor in physical therapy should be oriented within the sphere of biological sciences. In training more instructors in physical therapy we should avoid overemphasis on the methodology of teaching and choose those dedicated therapists whose knowledge of and enthusiasm for their field is such that there is unavoidable contagion that every student will catch.

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*Physical Therapy for Motor Disorders from Brain Damage .....Sarah Semans

*Employability of the Multiple-Handicapped.....William Usdane

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Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

APHASIA

See 6.

ART

12. **Arje, Frances Burton** *(Natl. Recreation Assn., 8 W. 8th St., New York 11, N.Y.)*

The fine arts as an adjunct to rehabilitation. *J. Rehab.* Nov.-Dec., 1960. 26:6:28-29, 51-52.

Art can make a special contribution to rehabilitation of the physically, mentally, or emotionally handicapped by providing social, intellectual, and esthetic experiences. Ability to express one's self through some form of the arts stimulates the imagination and relieves inhibitions often blocking rehabilitation efforts. Mrs. Arje is a member of the National Recreation Association's consulting service on recreation for the ill and handicapped.

ARTHRITIS

13. **Fowlks, E. W.** *(VA Hosp., Portland 7, Ore.)*

Adaptation to Marie-Strumpell arthritis, by E. W. Fowlks, J. A. Bridges, and Doris Hopkins. *Arch. Phys. Med. and Rehab.* Nov., 1960. 41:11:516-521.

A report of extensive research carried on from 1926 to 1959 to determine the posthospitalization adjustment of 56 male patients treated at the Portland VA Hospital for Marie-Strumpell arthritis. Effect of the disease on adjustment of the patient and his family was investigated through personal follow-up interviews. Data on marital and work status, age, education, employment before diagnosis, living arrangements, and status at follow-up are included. Factors responsible for motivation or its lack are considered from a medical, social, and vocational point of view. Reasons for failure to achieve rehabilitation in spite of physical improvement are examined.

See also 5.

ARTHRITIS—NEW JERSEY

14. **New Jersey Arthritis Project**

Keeping the arthritic working; proceedings of the workshop session on . . . sponsored by the . . . held at Helen Fuld Hospital, Trenton, on April 13, 1960. *Public Health News,* N.J. State Dept. of Health. Nov., 1960. 41:11:379-393.

The eight papers presented in this issue of *Public Health News* constitute the proceedings of the Workshop planned to consider the many needs of the arthritic and how those with whom he works and lives can aid in his readjustment.

Contents: Keynote address and case presentations, Peter J. Warter.—The role of organized labor in helping the arthritic, Angelo Calisti.—The role of the industrial physician, William D. Van Riper.—The role of the industrial nurse, Jane Voscek.—The role of social service, Anita Nicholson.—The role of community supportive services, Elizabeth Northcutt.—Workshop discussions, summarized by Florence Fiori.—Summary of Workshop, R. W. Lamont-Havers.

ARTHRITIS—INSTITUTIONS

15. **Cook, Roderick W., Jr.** *(Harrisburg, Pa.)*

Formation of the arthritis clinic. *Pa. Med. J.* Nov., 1960. 63:11:1618-1619.

Arthritis clinics in hospitals have been operating successfully in metropolitan areas for many years. Dr. Cook discusses briefly their purpose, organization, staff, admittance of patients, and services. Volunteer personnel, in addition to the professional staff, play an important role in many such clinics.

ARTHRITIS—MEDICAL TREATMENT

16. **Polley, Howard F.** *(Mayo Clinic, Rochester, Minn.)*

Adrenocortical steroid therapy for rheumatic diseases. *Arch. Phys. Med. and Rehab.* Nov., 1960. 41:11:497-503.

A discussion of the evolution of antirheumatic steroids, indications for their use, considerations in choice of steroids and their dosage, and the necessity for determining limits of tolerable dosage in the management of rheumatic diseases for which steroid therapy may be indicated. Adrenocortical steroids can be useful and reasonably safe when used as indicated and as a supplement to other appropriate nonsteroid therapy.

17. **Zankel, Harry T.** *(VA Hosp., Fulton St. and Erwin Rd., Durham, N.C.)*

The rationale of the physiatric management of arthritis; rheumatoid, osteoarthritis, and Marie-Strumpell arthritis. *South. Med. J.* June, 1960. 53:6:742-744.

The pathophysiologic process, symptoms and signs, and the objectives of treatment in various forms of arthritis are defined. Partial control of disabilities arising with progression of the disease may be achieved through proper methods of physical therapy applied before permanent changes have occurred.

BLIND

18. **Jordan, John E.** *(Glen Ellyn Public School, Glen Ellyn, Ill.)*

Counseling the blind, by John E. Jordan and William F. Hunter. *Personnel and Guidance J.* Nov., 1960. 39:3: 210-214.

Recognition of the personal-social needs of persons with handicapping conditions has resulted in counseling and guidance programs that are preventive as well as remedial. Counseling the blind requires a knowledge of the medical

aspects of the condition, of available community resources, and of the qualitatively different approach used by the counselor. Needs of blind children and adolescents are considered and an operational approach to counseling is suggested.

See also 67.

BLIND—MASSACHUSETTS

19. Mungovan, John F. *(14 Court Sq., Boston 8, Mass.)*

Aid to the blind; a tool of rehabilitation. *New Outlook for the Blind.* Nov., 1960. 54:9:313-320.

In 1951 the Massachusetts Division of the Blind was reorganized, with new emphasis on rehabilitation; the entire aid to the blind program was revised and its administration simplified. Changes in administrative policies are discussed, as are range of services provided. The role of the staff caseworker is explained. The program, now well organized, offers blind persons opportunity for rehabilitation, self-support, and self-care. The author is director of the Division of the Blind in Massachusetts.

BLIND—PSYCHOLOGICAL TESTS

20. Lebo, Dell *(Child Guidance and Speech Correction Clinic, 625 Ocean St., Jacksonville 2, Fla.)*

Projective methods recommended for use with the blind, by Dell Lebo and Roselyn Sherman Bruce. *J. Psychology.* 1960. 50:15-38.

A search of the literature revealed a limited number of projective tests recommended or used as evaluative procedures with blind persons. The authors describe projective methods suitable for psychological examination of the blind or partially sighted, evaluating what has been produced in this field and indicating seeming weaknesses in technics that have been abandoned. 69 references.

CEREBRAL PALSY—DIAGNOSIS

See 1.

CEREBRAL PALSY—EMPLOYMENT

See 77.

CEREBRAL PALSY—MEDICAL TREATMENT

21. Keats, Sidney *(31 Lincoln Park, Newark 2, N.J.)*

Surgery of the extremities in treatment of cerebral palsy. *J. Am. Med. Assn.* Nov. 5, 1960. 174:10:1266-1268.

In a comprehensive treatment program for the cerebral palsied, surgery of the extremities has a definite place. Dr. Keats notes the indications and contraindications for surgery, stating that the surgical procedure chosen depends upon careful muscle evaluation of the extremity involved. Data from clinical evaluation of 200 operations performed on 95 patients in a 10-year period are included. Results were most gratifying in improving muscle function and skill, in eliminating bracing and crutch support, and in the facilitation or shortening of the therapy program.

CEREBRAL PALSY—SPECIAL EDUCATION

See 58; 76.

CHILDREN—GROWTH AND DEVELOPMENT

22. Great Britain. Ministry of Health

The developmental progress of infants and young children, by Mary D. Sheridan. London, H. M. Stationery Off., 1960. 11 p. tabs. *(Reports on Public Health and Medical Subjects, no. 102)*

Intended to aid the physician in assessing developmental progress in normal and handicapped children, this pamphlet consists of explanatory text and tables describing the behavior of children at significant stages up to 5 years of age. Discovery of physical, mental, or emotional disabilities at an early age can result in more favorable prognosis for recovery or rehabilitation. In the tables reference is made to tests useful in determining and recording development at various stages.

Available in the U.S. from British Information Services, 45 Rockefeller Plaza, New York 20, N.Y., at 30¢ a copy.

CHILDREN'S HOSPITALS

23. Peay, Roberta *(Social Service Dept., Clinical Center, Natl. Institutes of Health, Bethesda, Md.)*

The emotional problems of children facing heart surgery. *Children.* Nov.-Dec., 1960. 7:6:223-228.

A clinical social worker describes reactions of parents and children who are admitted to the nursing unit of the National Heart Institute's surgical branch. Discussed are causes of tension in the child, the parents' reactions to recommendations made by the surgeon, how hospital personnel can help alleviate psychological trauma, and the referring physician's responsibilities in preparing the child and his parents for the surgical experience.

See also 9.

CHRONIC DISEASE

24. Chen, Edith *(Graduate School of Public Health, Univ. of Pittsburgh, Pittsburgh, Pa.)*

Family structure in relation to health and disease; a review of the literature, by Edith Chen and Sidney Cobb. *J. Chronic Diseases.* Nov., 1960. 12:5:544-567.

Data are from reports reviewed, mainly those written in English and concerned with the situation in Western culture. Five variables—parental deprivation, sibship size, position in sibship, marital status, and number of children—and the way they appear to relate to psychosomatic and mental diseases and certain aspects of health are considered in regard to their possible usefulness as measurements in future research. No attempt was made to cover the obvious effects of disease on family structure. 170 references.

CHRONIC DISEASE—INSTITUTIONS—ILLINOIS

25. Nicholson, Edna *(Institute of Medicine of Chicago, 86 E. Randolph St., Chicago 1, Ill.)*

Nursing homes and related facilities for care of the infirm and chronically ill. *Proc.,* Institute of Med. of Chicago. Sept. 15, 1960. 23:5:123-138.

More than 10,000 persons in the Chicago area who should receive care in good nursing homes or homes for the aged must live in rooming houses, hotels, and other accommodations not operated for care of the sick or infirm, according to statistics of a recently completed summary of

the need for and availability of facilities. Periodic estimates of this nature are compiled from current information gathered by the Institute's Central Service for the Chronically Ill. Includes 14 tables of data. A brief article summarizing the facts concerning extent of the problem was listed in *Rehab. Lit.*, Sept., 1960, #643.

COLLEGES AND UNIVERSITIES

See 79.

CONVALESCENCE—RECREATION

26. Little, Rufus R. *(Bergen Pines County Hosp., Paramus, N.J.)*

Recreation therapy in a general hospital. *Hosp. Management.* Dec., 1960. 90:6:36.

In same issue: A recreation program for long-term patients, Sally Pugh and David A. Gee. p. 37-39.

Results of a pilot program of recreational therapy in a 684-bed general hospital are described. A wide variety of activities calling for patient participation is an important adjunct to the treatment of patients, mostly elderly. Volunteers have contributed to success of the program.

Miss Pugh and Mr. Gee *(Jewish Hosp., St. Louis, Mo.)* describe the recreation program in a 500-bed hospital with typical medical and surgical acute services. Objectives and activities of programs in the Department of Child Psychiatry, an inpatient unit, in the adult psychiatry unit, and in the chronic and rehabilitation divisions are discussed. Costs of the four co-ordinated programs directed by the recreation therapist are mentioned.

DEAF—SPECIAL EDUCATION

27. Stokoe, William C., Jr. *(Gallaudet College, Washington 2, D.C.)*

The calculus of structure; a manual for college students of English. Washington, D.C., Gallaudet College, 1960. 92 p. Paperbound.

Intended for students who cannot hear speech or for those whose native language is not English, this manual offers an analytical explanation of English language structure. The author's purpose, as stated, is to explain the referential, semantic, and structural meaning of words and language and their relationships and to teach the principles of structure often neglected or obscured by grammarians. Methods for sentence and paragraph analysis are discussed as an aid to skillful writing free from errors.

Available from the Bookstore, Gallaudet College, Washington 2, D.C., at $2.00 a copy.

28. Stokoe, William C., Jr. *(Gallaudet College, Washington 2, D.C.)*

Sign language structure; an outline of the visual communication systems of the American deaf. Buffalo, N.Y., Univ. of Buffalo, 1960. 78 p. illus. *(Studies in Linguistics, Occasional Papers 8)*

By isolating elements of the sign language and giving them written symbols, Dr. Stokoe has supplied, for the first time, the means for putting into writing the visual language of the deaf. A short history of the sign language and its relation to spoken and manually spelled out English is given. The major portion of a paper by Dr. Anders S. Lunde on "The Sociology of the Deaf" is an interesting addition to the introduction. An explanation of American manual spelling and numeration systems, a glossary of terms, and a table of symbols needed for writing the language are given. Dr. Stokoe's book reports the first stage of a continuing research program supported by Gallaudet College and the American Council of Learned Societies.

Available from the Bookstore, Gallaudet College, Washington 2, D.C., at $2.00 a copy.

29. Volta Rev. Nov., 1960. 62:9.

Special issue: Books and reading.

Contents: Interesting the disinterested reader, Margaret Sinclair.—Home help with reading, Beatrice Ostern.—Current books.—A study of the need for academic classroom teachers of the deaf, Evan V. Johnston and D. Robert Frisina.—Teachers' forum: A unit on pets, Marjorie E. Smith; A reading aid, Sarah H. Abernethy; Number hop scotch, Bertha G. Lewis.—Book notes and reviews.—Read with your children, Helen Woodward.—Leisure reading for deaf children, Patricia Blair Cory.

Published by The Volta Bureau, 1537 35th St., N.W., Washington 7, D.C. *Volta Review* is available at 50¢ a copy ($5.00, yearly subscription).

DEAF—SPEECH CORRECTION

30. Chamberlain, Naomi H.

Teaching tips for teachers of the deaf; a manual of speech related activities . . . by Naomi H. Chamberlain under the direction of Sister M. Pauline. . . . Buffalo, N.Y., St. Mary's School for the Deaf, 1960. 36 p. illus.

Speech drills, activities, simple plays, and games found useful in stimulating oral speech usage by younger deaf children are offered as practical aids to the teacher. The methods, used in the primary grades of St. Mary's School for the Deaf, Buffalo, can be readily adapted for work with children in the intermediate and upper grades. The manual is not intended as a textbook or as a curriculum or teaching guide. The "Speech Scale" provides a means for measuring consistently children's speech growth.

Available from *American Annals of the Deaf*, Gallaudet College, Washington 2, D.C., at $1.00 a copy.

DRAMATICS

31. Rogers, Mary *(Royal Alexandra Hosp. for Children Convalescent Home, Collaroy Beach, New South Wales, Australia)*

Puppets; dramatic play with the long-term hospitalized child under eight, by Mary Rogers and Jennifer Harris. *Bul.*, Australian Assn. Occupational Therapists. July-Sept., 1960. p. 33-35.

Long-term orthopedic patients confined to the hospital can use dramatic play with puppets in learning to cope with frustrations caused by pain and inactivity. Spontaneous dramatization is stimulated by the therapist in a supportive role and by the interaction of children on the ward. Suggestions for puppet activities, equipment, and construction are included.

EPILEPSY—EMPLOYMENT

32. Risch, Frank *(3907 Manning Ave., Los Angeles 64, Calif.)*

New horizons in rehabilitation of the epileptic. *J.*

Assn. Phys. and Mental Rehab. Sept.-Oct., 1960. 14:5: 129-131, 141.

Epi-Hab of Los Angeles, a nonprofit corporation for rehabilitation of the epileptic, is an outgrowth of the experimental workshop program of the Veterans Administration. Results achieved in 4 years' operation are discussed in relation to safety record, actual work performance, social and economic benefits to workers, and placement of workers in competitive industry. Data from a survey of industrial management personnel, revealing attitudes toward the hiring of epileptic workers, are included. Epi-Hab is supported by a variety of community organizations, by personal contributions, and by aid from the U.S. Office of Vocational Rehabilitation.

EPILEPSY—PSYCHOLOGICAL TESTS

33. Parsons, Oscar A. *(Univ. of Oklahoma Med. Center, 800 NE 13th St., Oklahoma City, Okla.)*

Intellectual functioning in temporal lobe epilepsy, by Oscar A. Parsons and David E. Kemp. *J. Consulting Psych.* Oct., 1960. 24:5:408-414.

Cognitive abilities as measured by the Verbal and Performance Scale scores of the Wechsler Adult Intelligence Scale were studied in an epileptic population characterized by strictly unilateral temporal lobe EEG foci and pure psychomotor seizure patterns. Possible differences in cognitive ability patterns as measured by subtest scoring on the Wechsler Scale were studied, also, among psychomotor epileptics, generalized seizure (grand mal) epileptics, and a control group. Contrary to the prediction that Verbal Scale scores would be lower than Performance, findings implied that generalizations of earlier studies should be questioned. Performance IQ on the WAIS tends to be 3 to 5 points lower than Verbal IQ.

HEART DISEASE (CONGENITAL)

See 23.

HEMOPHILIA

34. Browne, William J. *(3811 O'Hara St., Pittsburgh 13, Pa.)*

Psychosocial aspects of hemophilia; a study of twenty-eight hemophilic children and their families, by William J. Browne, Mary A. Mally, and Ruth Powell Kane. *Am. J. Orthopsychiatry.* Oct., 1960. 30:4:730-740.

A 3-year study of the social and medical histories of 28 hemophilic children and their families revealed findings that indicate emotional factors can contribute to the timing of spontaneous bleeding episodes in hemophilia. The present paper is concerned with the patient's conflict about physical activity and movement and its relation to bleeding episodes, as well as the source and perpetuation of the conflict in the mother-child relationship. Because life expectancy for these patients has doubled in the past 15 years with improved medical treatment, it is important to give serious consideration to their emotional problems.

HOME ECONOMICS

35. Fowles, Beth H. *(Highland View Hosp., Harvard Rd., Cleveland 22, Ohio)*

Home evaluation procedure, by Beth H. Fowles, Helen Stewart, and Susan P. Mahan. *Phys. Therapy Rev.* Oct., 1960. 40:10:741-744.

Technics for home evaluation, developed by staff members of the Physical Medicine and Rehabilitation Department of Highland View Hospital over the past seven years, are described. Frequently, slight adaptations or adjustments of architectural features or home equipment can aid the severely disabled patient in maintaining his independence in the home after discharge. A looseleaf manual on home evaluation procedures was issued by the Hospital in 1957 (see *Rehab. Lit.*, Oct., 1957, #1230).

HOMEBOUND—CONNECTICUT

36. Wick, Homer C., Jr. *(Hartford Health Dept., Hartford, Conn.)*

Home care for long-term disability; first eighteen months experience of a new community health program in Hartford, by Homer C. Wick, Jr. (and others). *Conn. Health Bul.* Nov., 1960. 74:11:343-350.

A wide variety of services, co-ordinated by the Greater Hartford Home Care Program, provides comprehensive care and rehabilitation to patients with long-term disability. Data on 44 patients accepted for services since June, 1956, are included, as well as information on administration of the program. Resources of both voluntary and official organizations are used; each agency bills the Program monthly for services rendered. Further analysis of results after 5 years' continuous operation of the program is planned.

HOMEBOUND—PROGRAMS

37. American Hospital Association *(840 N. Lake Shore Dr., Chicago 11, Ill.)*

Proceedings of workshop on home care services. . . Chicago, April 20-22, 1960. Chicago, The Assn., 1960. 92 p. Spiral binding. Mimeo.

Sponsored by the American Hospital Association, American Medical Association, Blue Cross Commission, Blue Shield Medical Care Plans, and the U.S. Public Health Service, the invitational workshop explored means of stimulating the growth of organized home care services. Fifteen problem areas were identified; the recommendations dealt with ways of overcoming obstacles to the development of adequate comprehensive medical services in community home care programs.

Contents: Summary of Workshop, Dean W. Roberts.—Workshop objectives, David B. Wilson.—Workshop mechanics, Claire F. Ryder.—Home care programs; progress and potential, Cecil G. Sheps.—Community planning for health services: Facilities and financing, John R. Mannix.—Planning for the aged and chronically ill, Mrs. Frank M. Barry.—Reports (and recommendations) of discussion groups.

The report is issued by the American Hospital Association, 840 N. Lake Shore Dr., Chicago 11, Ill.

38. Delagi, Edward F. *(1777 Grand Concourse, New York 53, N.Y.)*

Rehabilitation of the homebound in a semi-rural area; a two-year experience with 120 patients, by Edward F. Delagi (and others). *J. Chronic Diseases.* Nov., 1960. 12:5:568-576.

An experimental project providing rehabilitation serv-

ices to suburban, homebound patients with chronic disease in northern Westchester County, New York, is described. Operated at a modest cost through the voluntary visiting nurse agency with the county public health department and local physicians co-operating, the project and results have been so worthwhile that establishment of similar services elsewhere is recommended. Roles of the nurse and therapist are defined and results of home care treatment analyzed.

HOMEBOUND—SURVEYS—NEW YORK

39. Jenkins, Shirley *(Federation of the Handicapped, 211 W. 14th St., New York 11, N.Y.)*

Some characteristics of homebound adolescents in New York City. *Exceptional Children.* Nov., 1960. 27:3:175-182.

Records of the total population of homebound high school students in New York City were studied and data on age, sex, disability, length of time on homebound instruction, school grades, IQ, and standardized test scores were tabulated. This survey represented the initial research conducted before setting up a pilot project on prevocational training for such students. The High School Homebound Project, initiated by the Federation of the Handicapped in September, 1959, serves a group of 50 (less than 10% of the total on homebound instruction). Workshop experience, vocational counseling, social casework, group and individual therapy are provided at a prevocational training center two days a week. Data from the survey are included.

HOSPITAL SCHOOLS

See 9.

HYDROCEPHALUS

40. Taylor, A. R. *(Royal Victoria Hosp., Belfast, Ireland)*

Long-term follow-up of hydrocephalic infants treated by operation, by A. R. Taylor, J. R. Milliken, and P. P. Davison. *Brit. Med. J.* Nov. 5, 1960. 5209:1356-1359.

In same issue: Surgical treatment of hydrocephalus (an editorial). p. 1372-1373.

Five surviving children from a group of eight who underwent surgery for communicating hydrocephalus have been studied by a psychologist, psychiatrist, and a neurological surgeon 7 years after operation. Case histories report the present status of each. Physical, emotional, and intellectual status of each is considered in the normal range. Prognosis for survival of hydrocephalic infants is considered good, provided early complications of surgery are avoided and the child protected from high intracranial pressure for approximately 2 or 3 years.

The editorial reviews results of various surgical procedures used in the past two decades for hydrocephalus, both the communicating and noncommunicating types.

HYDROTHERAPY

41. Bierman, William *(Univ. of California Med. School, San Francisco, Calif.)*

European spas, by William Bierman (and others). *Arch. Phys. Med. and Rehab.* Nov., 1960. 41:11:504-513.

A report of a tour of spas in Germany, Austria, and Italy made in 1958 for the purpose of evaluating the effectiveness of spa therapy. Discussed are qualifications of staffs, spa facilities, the physiologic action of spa procedures, and the rationale for treatment of various diseases.

HYPNOSIS

See 10.

MENTAL DEFECTIVES

42. Farber, Bernard

Family crisis and the retarded child, by Bernard Farber, William C. Jenne, and Romolo Toigo. Washington, D.C., Council for Exceptional Children, 1960. 66 p. tabs. *(CEC research monograph, Ser. A, no.1)*

Two earlier research reports by Dr. Farber, conducted at the Institute for Research on Exceptional Children, University of Illinois, were concerned with general aspects of the problem presented by the severely retarded child in the family (see *Rehab. Lit.,* May, 1959, #426, Apr., 1960, #258; see also Aug., 1960, #596). The current report focuses attention on the nature of family crises caused by presence of retarded children and factors affecting parents' decisions to institutionalize them. Results of analysis of the data on 268 families and of the testing of 8 hypotheses are summarized as they relate to findings of the earlier studies, the nature of family crises, and parents' willingness to institutionalize the retarded child. Interpretations made in the earlier reports are supported by the current findings and emphasize the role of status-maintenance norms and values, organization of the family, and the impact of the child on his parents in the decision to institutionalize.

Available from the Council for Exceptional Children, 1201 16th St., N.W., Washington 6, D.C., at $2.00 a copy.

See also 3.

MENTAL DEFECTIVES—U.S.S.R.

43. Wortis, Joseph *(152 Hicks St., Brooklyn 2, N.Y.)*

Mental retardation in the Soviet Union. *Children.* Nov.-Dec., 1960. 7:6:219-222.

Mental retardation is viewed basically in the same way in Russia as in the United States—as a problem involving biological equipment and educational opportunity. Dr. Wortis, during his 7-week tour of Russia, did notice important differences, however, in approach and emphasis among Soviet psychologists and educators. Services and research compare favorably with those in the United States and in some respects are considered superior. Vocational placement for retarded adults presents no difficult problem and special education is considered a branch of science.

MENTAL DEFECTIVES—DIAGNOSIS

44. Burns, Robert C. *(Children's Orthopedic Hosp., 4800 Sand Point Way, Seattle 5, Wash.)*

Behavioral differences between brain-injured and brain-deficit children grouped according to neuropathological types. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:326-334.

From a total of 1,400 consecutive patients referred to the psychology department of a large children's hospital, 23 were classified as having either brain tissue injury or brain underdevelopment or maldevelopment. Consistent behavioral differences, as measured by the Wechsler Intelligence Scale for Children, were found in both group and individual scores. An inference from this study is that children classified as having brain underdevelopment or maldevelopment have a poor prognosis for intellectual development within the normal range. Combined neurological, biochemical, and psychological indices of brain function may improve diagnostic, prognostic, and etiologic knowledge of differing types of brain injury or maldevelopment.

45. Tarjan, George *(Pacific State Hosp., Pomona, Calif.)*

Statistical expectations of selected handicaps in the mentally retarded, by George Tarjan, Harvey F. Dingman, and Curtis R. Miller. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:335-341.

Another in the series of studies concerned with population movement of mental defectives and related physical, behavioral, social, and cultural factors (for previous articles, see *Rehab. Lit.,* Sept., 1958, #1000, and Nov., 1959, #842). This paper compares selected physical handicaps in newly admitted and resident patients, with frequencies of disabilities that influence nursing care plotted against chronological age and IQ. Findings stress the need for intensified habilitation programs; they are also useful in estimating probabilities of these handicaps in patient groups where age and IQ are known.

MENTAL DEFECTIVES—EMPLOYMENT

46. Cohen, Julius S. *(Edward R. Johnstone Training and Research Center, Bordentown, N.J.)*

An analysis of vocational failures of mental retardates placed in the community after a period of institutionalization. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:371-375.

Reported reasons for the return of students to a short-term residential training center after employment in the community are analyzed. Factors related to 73 unsuccessful placements of 57 students are examined. Limitations of training at the school and two primary areas needing further research in order to insure more successful placement are discussed.

MENTAL DEFECTIVES—INSTITUTIONS

47. Shafter, Albert J. *(Southern Illinois Univ., Carbondale, Ill.)*

A philosophy of institutional administration. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:313-317.

A discussion of the applicability of the concepts of "milieu therapy" or the "therapeutic community" to administration of residential institutions for the mentally retarded. Both concepts stress the idea of professional and nonprofessional personnel interacting with patients in an emotionally correctional fashion. The author believes, however, that an environment primarily corrective in the social and educational sense is more suited for the residential institution for mental retardates. No pat solutions are offered for administrative problems, some of which are mentioned. The article does suggest areas for re-examination and possible research.

See also 80.

MENTAL DEFECTIVES—INSTITUTIONS—GREAT BRITAIN

48. National Association for Mental Health (Gt. Brit.) *(Maurice Craig House, 39 Queen Anne St., London, W. 1, England)*

"Fairhaven," a hostel for educationally subnormal school leavers. *Mental Health.* Autumn, 1960. 19:3: 98-101.

A memorandum prepared for the British Council for Rehabilitation, describing the administration of and services provided by the hostel opened by the Association in 1958. Characteristics of the boys served are discussed briefly; the majority come to the hostel from special boarding schools and are under the care of Local Health Authorities. Family casework plays an important part in aftercare of educationally subnormal and maladjusted school leavers.

MENTAL DEFECTIVES—INSTITUTIONS—NEW JERSEY

49. Eadline, James D.

The Training School at Vineland; a historical sketch. *Welfare Reporter,* N.J. Dept. of Institutions and Agencies. Oct., 1960. 11:4:185-198.

Early days at Vineland Training School, the impact of its founders' and staff members' contributions to the field of mental deficiency, world-wide acceptance of research results of its scientific laboratory, and the growth of state institutions for the mentally defective in New Jersey are highlighted in this account of 72 years' history of the School.

This entire issue of *Welfare Reporter* commemorates 50 years of psychological services in the State Department of Institutions and Agencies. Other articles included are: A personalized story of the first state-supported psychological clinic in New Jersey, J. E. Wallace Wallin.—Psychological studies at the State Home for Girls, 1912-14, Margaret Otis.—New Jersey state psychology in the Twenties, Edgar A. Doll.—Recollections of yesteryear: I. Jamesburg, August K. Eccles; II. Marlboro State Hospital, Robert Stone; III. North Jersey Training School, Robert M. Beechley; IV. New Jersey State Prison, James D. Jackson.—1919-1939; a historical note, J. Q. Holsopple.—Notes on the early development of the Rutgers psychological clinic, Anna Spiesman Starr.—The post-war decade, 1946-1956, Maurice G. Kott.—New Jersey Institutions and Agencies; psychological perspectives, Henry P. David.—A New Jersey chronology of social welfare and psychology, 1572-1960.

MENTAL DEFECTIVES—PARENT EDUCATION

50. Drayer, Carl *(Morris J. Solomon Clinic, Jewish Hosp. of Brooklyn, 555 Prospect Pl., Brooklyn 16, N.Y.)*

The informing interview, by Carl Drayer and Elfriede G. Schlesinger. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:363-370.

Administration of the services of a clinic for the re-

habilitation of mentally retarded children is described briefly. Evaluation studies, taking one to three months, a case conference with parents and the child, and formulation of the diagnosis and treatment plan precede the informing interview, usually conducted by the physician in charge of the child's case. Technics and specific focus of the interview are discussed. The procedure could easily be adapted to management of children with other types of handicaps.

MENTAL DEFECTIVES—SPECIAL EDUCATION

51. Alprin, Stanley I. *(26 Yorktown Rd., Bordentown, N.J.)*

The effect of organizational patterns on programs for trainable children in New Jersey's public schools. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:376-380.

Strengths and weaknesses of three major organizational patterns for special classes for trainable mentally retarded children currently operating in New Jersey public schools are considered. Virtues of the multi-unit center versus the single-unit plan are pointed out. Also discussed are the relationship of organizational pattern to curriculum development, supervision, parent education, and stability of the programs. Superior programs are needed for trainable children if they are to achieve their maximum development.

52. Baumgartner, Bernice B.

Helping the trainable mentally retarded child; a handbook for teachers, parents, and administrators. New York, Teachers Coll., Columbia Univ., 1960. 71 p. *(TC ser. in special education; ed. by Maurice H. Fouracre)* Paperbound.

In addition to its usefulness as a guide for administrators and teachers, this monograph should help parents understand the objectives of the training program. Practical aids are the suggestions on individual approaches to different children and specific methods the inexperienced teacher will find of value. The checklist provided for administrators should be an aid in evaluating existing programs or in planning the new program. Methods are equally adaptable to the public school class, the residential program, or to classes initiated by local parents' organizations.

Available from Bureau of Publications, Teachers College, Columbia University, New York 27, N.Y., at $1.00 a copy.

53. Deno, Evelyn *(230 Institute of Child Welfare, Univ. of Minnesota, Minneapolis, Minn.)*

Community coordinated effort in vocational training for the retarded. *Exceptional Children.* Nov., 1960. 27:3: 166-172.

Four educational patterns of terminal programs for retarded students at the secondary level have been developed for trial in Minneapolis public schools. Mrs. Deno, a special education and rehabilitation consultant to the Minneapolis public schools, describes objectives of each pattern and the type of students to be served. Operation of the programs will be evaluated in June, 1962, to determine effectiveness of program policies.

54. Goldstein, Herbert *(Institute for Research on Exceptional Children, Univ. of Illinois, Champaign, Ill.)*

Report on International Conference of Teachers of Backward Children. *Exceptional Children.* Nov., 1960. 27:3:139-146.

A report of a conference held in April, 1960, organized by the British Guild of Teachers of Backward Children for the purpose of exchanging views on programs and procedures in the education and training of the mentally retarded. Mr. Goldstein summarizes differences in programs in countries other than the United States and reviews in more detail British research, educational provisions for the educably subnormal and trainable, and teacher training.

55. Hudson, Margaret

Procedures for teaching trainable children. Washington, D.C., Council for Exceptional Children, 1960. 71 p. tabs. *(CEC research monograph, Ser. A, no. 2)*

Conducted under the U.S. Office of Education's grant program, this research study analyzed 43 specific teaching technics classified according to eight major areas of teaching methods, identified types of lessons being taught in trainable classes, suggested problem areas, and presented a tentative checklist of teacher competencies. Useful applications of the technics to all areas of the training program are suggested in some detail. Findings of the current study revealed a variety of research problems needing further investigation.

Available from the Council for Exceptional Children, 1201 16th St., N.W., Washington 6, D.C., at $2.00 a copy.

MENTAL DISEASE—FICTION

See p. 12.

MENTAL DISEASE—PROGRAMS

56. Olshansky, Simon S. *(Service for Retarded Children, Cambridge, Mass.)*

Vocational rehabilitation and the ex-mental patient. *J. Rehab.* Nov.-Dec., 1960. 26:6:17-19, 40-45.

Although this article may seem highly critical of the state-federal rehabilitation program, it has been published in the hope that some of the issues raised may be of help in eliminating inequities in the provision of vocational rehabilitation services for exmental patients. Mr. Olshansky offers some constructive suggestions for overcoming resistance to changes in legislation and to administration of services intended for *all* disabled.

See also 74.

MENTAL DISEASE—SPECIAL EDUCATION

57. Johnson, John L. *(Lafayette Clinic, 951 E. Lafayette Ave., Detroit, Mich.)*

Learning problems in a schizophrenic child, by John L. Johnson and Kristen D. Juul. *Exceptional Children.* Nov., 1960. 27:3:135-138, 146.

Reports in some detail the case history of an 11-year-old schizophrenic boy who failed to make any school progress during two years' treatment in the children's unit of a psychiatric hospital. Methods used in daily tutoring in an effort to improve his reading ability are discussed; in spite of all efforts he did not progress beyond the first-grade level. Findings of the study are analyzed. Mr. Johnson is a teacher at the Lafayette Clinic; Mr.

Juul formerly was supervisor of special education at the clinic.

See also p. 12.

MUSIC

58. Sato, Chiyoko *(Municipal Komei School for the Physically Handicapped, Tokyo, Japan)*

Musical aptitude of cerebral palsied children. *Cerebral Palsy Rev.* Nov.-Dec., 1960. 21:6:3-8.

Using a musical aptitude diagnostic test published by the Tanaka Educational Research Institute in 1954, the writer tested 107 cerebral palsied children. Although their expressions in music were of poor quality and full of errors, aptitude itself was not considered inferior. The correlation between musical aptitude and intelligence in individual children appeared, to the writer, to be significant. Data are classified according to type of cerebral palsy, intelligence, and aptitude. (For Miss Sato's previous article, see *Rehab. Lit.,* Dec., 1960, #952.)

NEUROLOGY

See 1.

NURSING

59. Allgire, Mildred J.

Nurses can give and teach rehabilitation; a manual, by Mildred J. Allgire and Ruth R. Denney. New York, Springer Publ. Co., 1960. 61 p. illus.

Written in nontechnical language, this manual describing procedures and equipment used in physical rehabilitative nursing is suitable for use in teaching the fundamentals of care and the principles involved. Methods are adaptable for patients of all ages and for a variety of disabling conditions. It lists those conditions that frequently benefit from physical treatment, illustrates and describes minimum exercises to prevent deformity and increase strength, and discusses self-help activities. The teaching outline has been used in Indiana since 1955. The authors, director and consultant, respectively, of Nursing and Therapy Services, Indiana Division of Services for Crippled Children, have worked closely with rehabilitation specialists at Indiana University Medical Center.

Available from Springer Publishing Co., 44 E. 23rd St., New York 10, N.Y., at $1.25 a copy, plus 15¢ postage (less in quantity orders).

OCCUPATIONAL THERAPY

See 2; 7.

OLD AGE

60. Kent, Herbert *(Pasteur Med. Bldg., 1111 N. Lee St., Oklahoma City, Okla.)*

Geriatric restoration to self-care. *Med. Times.* Apr., 1960. 88:4:455-460.

Goals in restoring the geriatric patient to usefulness are achieved mainly through retraining in the activities of daily living—grooming and ability to walk and travel, to use ordinary transportation, and to communicate either orally or in writing. Modifications in technics of self-feeding and bathing and in wearing apparel are discussed briefly; self-help devices are sometimes useful in overcoming disability and improving morale in the severely handicapped person. Dr. Kent describes community facilities needed for effective geriatric rehabilitation programs.

OLD AGE—EMPLOYMENT

61. Employment Security Rev. Nov., 1960. 27:11.

Title of issue: Ability is ageless; serving the over-40 worker.

Contents: The older worker; an action program, James P. Mitchell.—Spotlight on aging, Robert H. Grant.—Older workers and the Federal Council on Aging, Warren T. Roudebush.—Teamwork gets the job done, John Corrie.—Experience unlimited, Ralph Moore.—Minnesota Governor's Conference on Aging, Merle S. Kinvig.—Effective publicity campaigns, Lewis H. Evans.—Operation Joblift, Eleanor B. Kuhfuss.—Florida's job clinics for older workers: St. Petersburg, Betty Phillips; Miami, Lucius A. Daniel.—The older worker in the Old Dominion, Ellen S. McKenry.—A new approach to older worker problems, Harold W. Williams.—Job development for older workers, Thomas R. Downs.

Employment Security Review is published by the U.S. Bureau of Employment Security; single copies available from U.S. Superintendent of Documents, Washington 25, D.C., at 20¢.

OLD AGE—INSTITUTIONS

62. Goldmann, Franz *(Council of Jewish Federations and Welfare Funds, 729 Seventh Ave., New York 19, N.Y.)*

Residents of homes for the aged. *Geriatrics.* May, 1960. 15:5:329-337.

Socioeconomic and health conditions in 530 residents of 5 homes for the aged in different communities were studied in 1958; this article reports major findings and data of interest to those responsible for providing health services to the aged. Dr. Goldmann emphasizes the need for adequate public assistance to homes for the aged, especially those with more than 50 beds. The high prevalence of physical and mental impairment revealed suggests changes in policy for the operation of such homes. For another article reporting on the same study, see *Rehab. Lit.*, Nov., 1960, #847.

PARALYSIS AGITANS—MEDICAL TREATMENT

63. Bertrand, Claude *(1392 Sherbrooke St. East, Montreal 24, Canada)*

Surgical treatment of Parkinsonism; the use of a pneumotaxic guide with recording and stimulation, by Claude Bertrand, Napoleon Martinez, and Claude Gauthier. *Canad. Med. Assn. J.* Apr. 30, 1960. 82:921-923.

Surgical lesions produced by the technic described here, using a fine blunt-wire leucotome, have produced marked improvement in more than 80% of patients with tremor, rigidity, or akinesia resulting from Parkinson's disease. Chief contraindications to the procedure are mental alterations or severe organic disease. Bilateral

procedures are used selectively in younger or mentally alert patients. Results in 100 patients are reviewed.

64. **Gillingham, F. J.** *(Dept. of Surgical Neurology, Univ. of Edinburgh, Scotland)*

The surgical treatment of Parkinsonism, by F. J. Gillingham (and others). *Brit. Med. J.* Nov. 12, 1960. 5210: 1395-1402.

In same issue: Surgical relief of Parkinsonism (an editorial). p. 1437.

Thermal electrocoagulation lesions in the globus pallidus, internal capsule, and thalamus, separately or in combination, have been used in the surgical treatment of patients with Parkinsonism in Edinburgh. Evolution of the treatment over the past 5 years is described. Of 60 patients treated, 53 (88%) have had tremor and/or rigidity abolished or significantly reduced without complications in the treated limbs. The method used is unique in allowing creation of lesions in the globus pallidus, internal capsule, or thalamus with one electrode track at different depths. Indications and contraindications for selection of patients for surgery are discussed.

The editorial reviews various surgical procedures used in the treatment of Parkinsonism, emphasizing the advantages of accurate stereotaxic technics.

PARAPLEGIA—MEDICAL TREATMENT

65. **Engel, Joseph P.** *(920 Seventh St. South, Minneapolis 4, Minn.)*

Management of patients with spinal cord injury. *J. Am. Med. Assn.* Nov. 5, 1960. 174:10:1263-1265.

Serving as a comprehensive rehabilitation center since 1956, the Elizabeth Kenny Institute of Minneapolis has accepted for treatment 55 patients with spinal injuries. Staff experience with these patients is reviewed; data on cause of spinal cord trauma, age range of patients, and average length of hospital stay are included. Surgical procedures used, complications in treatment, and results achieved are discussed. The role of the referring physician is explained.

PHYSICAL MEDICINE

66. **Bennett, Robert L.** *(Warm Springs Foundation, Warm Springs, Ga.)*

Use and abuse of certain tools of physical medicine. *Arch. Phys. Med. and Rehab.* Nov., 1960. 41:11:485-496.

Mobilization, muscle re-education, functional training, and orthetic devices, properly used, can prevent and overcome disability. When misused, each can endanger recovery and cause severe disability. Dangers inherent in "stretching" technics, in therapeutic exercise, and in the stress of functional activity are explained in relation to their usefulness as essential tools of physical medicine. Dr. Bennett's paper was presented at a seminar sponsored by the American Rehabilitation Foundation in 1960.

See also 8; 41.

PHYSICAL THERAPY—STUDY UNITS AND COURSES

See 11.

PLAY THERAPY

67. **Rothschild, Jacob** *(103-10 Queens Blvd., Forest Hills 75, N.Y.)*

Play therapy with blind children. *New Outlook for the Blind.* Nov., 1960. 54:9:329-333.

An article based on observations and impressions obtained at the Service Bureau for Blind Children, a department of the Industrial Home for the Blind, Brooklyn. The majority treated were of preschool age, although children up to 12 years of age have been included. All were congenitally and totally blind. Play therapy with blind children demands a modified approach since they may not be accustomed to express and involve themselves in play situations. Adaptations in therapy and the role of the therapist as an "instructor" are discussed. Where mothers were also involved in therapy, children showed more beneficial results.

See also p. 12; 31.

READING

See 29.

RECREATION

See 7; 12; 26; 31.

REHABILITATION

68. **Novis, Frederick W.** *(33 Garden St., Hartford, Conn.)*

Quantitative measurement in the initial screening of rehabilitation potential, by Frederick W. Novis, Joseph L. Marra, and Lucian J. Zadrozny. *Personnel and Guidance J.* Dec., 1960. 39:4:262-269.

Describes a technic for evaluating clients' vocational rehabilitation potential, using only reported case data from medical reports, earning records, and educational and occupational histories. The experimental scale developed as a part of the research project provides a rating system whereby personal bias of the agency counselor and extraneous factors are eliminated from the evaluation process. Use of the Rehabilitation Screenometer results in objective decisions and consistent, uniform judgments. The methods and principles embodied in the Screenometer can be applied to further research in case assessment and analysis. For copies of the device and operating instructions, write to Dr. Novis at the address given above.

69. **Pinckney, Theodore R.** *(Howard Univ., Washington, D.C.)*

Physical rehabilitation of the medical patient. *J. Natl. Med. Assn.* Nov., 1960. 52:6:425-428.

Rehabilitation is still a medical problem under the direction of the physician, who must recognize, however, the need for assistance from many allied professions. In addition to the general discussion of economic, social, and medical aspects of rehabilitation, Dr. Pinckney considers several special areas of disability and the improvement possible with comprehensive rehabilitation technics.

70. **Shields, Charles D.** *(3800 Reservoir Rd., Washington 7, D.C.)*

The challenge of disability to medicine; emphasizing

the need for timely recognition of impaired function and the application of specific rehabilitative procedures, by Charles D. Shields and Bernard D. Daitz. *J. Am. Med. Assn.* Nov. 19, 1960. 174:12:1611-1616.

In reviewing the social, economic, and physical aspects of disability and the magnitude of the problem of chronic illness, the writers emphasize the physician's responsibility for initiating preventive measures in the early phase of the patient's illness. He should also keep abreast of current medical developments, educate the public on need for rehabilitation services, and aid in developing acceptable prepayment insurance plans to cover costs of comprehensive care.

See also 56.

REHABILITATION—WISCONSIN

71. **Health,** Quart. Bul. Wis. State Board of Health. Oct., Nov., Dec., 1960. 14:12.

Title of issue: Rehabilitation.

Contents: Rehabilitation activities of the State Board of Health, Milton Feig.—Demonstrating rehabilitation in a community, G. M. Shinners.—Rehabilitation in proprietary nursing homes, Paul F. Fleer.—Rehabilitation nursing through staff education, Bernice Brynelson.—Rehabilitation in action; a case history in photos, Corrine Blazek.—The family physician and his role in rehabilitation, Ray Piaskoski.—In our midst: A community center for rehabilitation, T. S. Allegrezza.—Rehabilitation, a co-operative effort (summaries of group discussions): (1) The role of community organizations, Roy W. Brooks.—(2) The role of volunteer health agencies, William G. Shearer.—(3) Integrating and coordinating efforts of professional service agencies, R. K. Wilcox.—(4) Integrating and coordinating efforts of professional rehabilitation disciplines, Alice Sanders.—The role of vocational rehabilitation referrals, John A. Kubiak.

Health is published by the State Board of Health, 1 W. Wilson St., Madison 2, Wis.

REHABILITATION—STUDY UNITS AND COURSES

72. **Worthington, Catherine** *(The National Foundation, 800 Second Ave., New York 17, N.Y.)*

The National Foundation Conference on Teaching Rehabilitation Concepts and Techniques, 1959. *J. Med. Education.* Nov., 1960. 35:11:1054-1057.

A summary of the Conference during which Dr. William S. Clark spoke on the role of the long-term patient in plans for teaching medical students the elements of comprehensive care. Dr. John L. Caughey discussed students' readiness for a rehabilitation teaching program. Dr. Lyman Stowe described Stanford University Medical School's plan of medical education and how comprehensive care is taught within the plan; Dr. Rodney Beard, coordinator of rehabilitation teaching, illustrated how principles of care are introduced into the curriculum.

See also 11; 59.

RH FACTOR

73. **Price, Joseph J.** *(Misericordia Hosp., 54th and Cedar Ave., Philadelphia 43, Pa.)*

Management of the pregnant Rh negative female. ***Pa. Med. J.*** Nov., 1960. 63:11:1632-1637.

A summary of the latest concepts in diagnosis and management of the pregnant Rh negative, sensitized female. Hereditary aspects, diagnostic methods of testing for antibodies, and the ABO incompatibility and its diagnosis are discussed. 35 references.

SHELTERED WORKSHOPS

74. **Benney, Celia** *(Altro Health and Rehab. Services, 373 Fourth Ave., New York, N.Y.)*

Casework and the sheltered workshop in rehabilitation of the mentally ill. *Soc. Casework. Nov.,* 1960. 41:9: 465-472.

Among the co-ordinated services of Altro Health and Rehabilitation Services, casework provided within the sheltered workshop setting helps the patient return to normal work in the community. Mrs. Benney discusses three important aspects of the casework process—enabling the client to accept workshop placement and the professional services offered, the use of the workshop as a diagnostic tool in client assessment, and the treatment process in the workshop. Case history material illustrates problems encountered in rehabilitating such clients.

SOCIAL SERVICE—CASEWORK

See 4; 9.

TUBERCULOSIS—PSYCHOLOGICAL TESTS

75. **Santorum, Aldo** *(VA Center, Martinsburg, W. Va.)*

A cross-validation of the House-Tree-Person drawing indices predicting hospital discharge of tuberculosis patients. *J. Consulting Psych.* Oct., 1960. 24:5:400-402.

A report of a study to cross-validate theoretical implications of an earlier study concerning certain signs from the House-Tree-Person Test claimed to predict patients who will receive maximum hospital benefit and those who will leave against medical advice. None of the seven signs of the original study, reported to differ significantly between the two groups, was found to hold up on cross-validation. In view of the great discrepancy between results of the present and earlier studies, implications of the original study should be utilized with caution.

TYPING

76. **Smith, LaVerna A.**

A method of typing for the handicapped; one-hand touch typing. *Cerebral Palsy Rev.* Nov.-Dec., 1960. 21:6: 11-12.

Disabled by poliomyelitis at an early age, Miss Smith lacks sensitivity in the fingers of her right hand. In spite of this obstacle, she successfully completed a course for medical secretaries and is presently employed in a one-girl office by a private physician. She describes the method she uses and some of the variations used to meet individual needs of handicapped typists. As long as regular work requirements can be met, employment opportunities for the one-hand typist, she believes, are many and varied.

VOCATIONAL GUIDANCE

77. Helfand, Abraham *(Institute for the Crippled and Disabled, 400 First Ave., New York 10, N.Y.)*

Vocational counseling in work evaluation of the cerebral palsied. *J. Rehab.* Nov.-Dec., 1960. 26:6:5-6, 46-50.

Five years' experience in evaluating work potential of cerebral palsied clients at the Institute for the Crippled and Disabled has shown the importance of short-term vocational counseling. Mr. Helfand, senior vocational counselor, discusses the Institute's team approach, methods for vocational evaluation, the evaluator's and counselor's roles, and specific technics of counseling.

78. Illinois. Commission for Handicapped Children *(160 N. LaSalle St., Chicago 1, Ill.)*

Training for tomorrow; a statement on prevocational services for handicapped youth in public schools of Illinois. Chicago, The Commission, 1960. 15 p.

This statement prepared by special education personnel to promote wider use of vocational guidance, training, placement, and social adjustment of handicapped children evaluates the current status of such programs in Illinois, the unmet needs, and how prevocational services can be adapted to local school programs. Basic program components and services are outlined.

79. Mase, Darrel J.

The assessment of college experience of severely handicapped individuals, by Darrel J. Mase and Charles F. Williams. Gainesville, Fla., Coll. of Health Related Services, Univ. of Fla., 1960. 46 p. figs., tabs.

Supported in part by a research grant from the U.S. Office of Vocational Rehabilitation, this follow-up study evaluates the occupational success and personal adjustment of 243 severely handicapped college graduates as compared with 224 severely handicapped high school graduates. This is one of the very few studies regarding the use made of college education by handicapped persons. The findings, bearing out conclusions of earlier, more limited studies, should be valuable to rehabilitation counselors. No major differences in occupational success between the severely handicapped and the nonhandicapped college graduates were found. Emotional adjustment is essentially the same for both groups. The study was made under the direction of Dr. Mase, Dean of the College of Health Related Services, J. Hillis Miller Health Center, University of Florida.

See also 18; 39; 46; 53.

VOLUNTEER WORKERS

80. Hartford, Robert J. *(Ft. Wayne State School, Ft. Wayne, Ind.)*

A volunteer program in a state school for the mentally retarded; an administrative viewpoint. *Am. J. Mental Deficiency.* Nov., 1960. 65:3:318-321.

The assistant superintendent of a 2,000-bed state facility for the mentally retarded, located at Ft. Wayne, Ind., discusses the administration, objectives, drawbacks and benefits of a volunteer program in a state institution. A properly organized and administered program not only provides supplementary services and goods but also serves as an effective public relations tool and a link to the community.

WHEEL CHAIRS

81. Nyquist, Roy H. *(VA Hosp., Long Beach, Calif.)*

How to prescribe a wheelchair, by Roy H. Nyquist and Ernest Bors. *J. Assn. Phys. and Mental Rehab.* Sept.-Oct., 1960. 14:5:125-128, 141.

An article based on 9 years' experience with weekly conferences on wheelchairs at the Spinal Cord Injury Center, Long Beach VA Hospital, and the individual prescription of wheelchairs. Responsibilities of various members of the wheelchair conference team, general principles of selection and prescription, and variations in all parts of the chair to meet individual needs are discussed.

(Continued from page 13)

and pamphlets on the subject have been compiled under the direction of Dr. Watson of Michigan State University's Department of Horticulture, this is the first book of its kind to give detailed information on conducting a year-round therapy program. Briefly discussing the historical background of horticulture as therapy, the authors point out its value in various treatment settings, with persons of all age groups, and in total care of specific conditions and diseases. Administration of the program, use of volunteers, equipment needed, hospital etiquette, and projects recommended to meet individual patients' needs are covered. A dozen charts analyze the therapeutic benefits of the typical activities in therapy projects, and a chapter is devoted to examples of many successful programs. Lists on sources of supplies and books recommended for volunteers and patients conclude a lively and really "down-to-earth" book. The possibilities of this form of activity for both recreation and therapy are endless.

8

Third International Congress of Physical Medicine . . . Abstracts of Papers Presented

By: **International Congress of Physical Medicine**

1960. 175 p. *(Excerpta Medica Internatl. Congress ser. no. 28)* Available in the U.S. from Excerpta Medica Foundation, New York Academy of Medicine Building, 2 E. 103rd St., New York 29, N.Y. $5.00 a copy.

ABSTRACTS OF 104 PAPERS presented at the International Congress, Washington, D.C., August 21-26, 1960, are given in English, French, Spanish, and German. A wide range of subjects, including research findings; modalities of physical medicine and physical therapy used in the treatment of disabilities; use of hypnosis; equipment and appliances; professional training; and the medical, psychological, social, and vocational aspects of rehabilitation, were discussed by authorities from the United States and foreign countries. Author index.

Events and Comments

Severely Handicapped Students at Wayne State University Surveyed

LOUIS CANTONI, Ph.D., associate professor of education and co-ordinator, Rehabilitation Counselor Training Program, at Wayne State University, Detroit, Mich., reports that in the semester ending June, 1960, 48 of the total 19,799 students enrolled had severe disabilities. Fifteen (31% of the 48) were blind. Thirteen (27%) were in wheel chairs as the result of poliomyelitis or spinal cord injuries. The remaining 20 (42%) primarily had orthopedic handicaps or cardiac conditions.

A counselor versed in the meaning of disability helps the students during admission. She also supplies them with information, as needed, regarding psychological counseling, speech therapy, physical therapy, housing, social and recreational facilities, parking, pusher service, and ramp entrances to buildings. Where the blind are concerned, the counselor provides for the use of tape recorders, typewriters, Braille writers, reader service, and proctoring of examinations.

The major fields of study of the 48 students covered practically the whole range of college offerings. Fifteen of the 48 (31%) already had full-time jobs. Of special interest was the finding that 8 of the 15 blind students (53%) had full-time employment while they attended school part time.

T. J. Nugent Comments on

Campus Planning for Handicapped Students Benefits All

"ONE OF THE OLDER buildings on (the University of Illinois) campus presented insoluble problems in regard to ramping at any of the established entrances. Subsequently, a ramp (for use by wheelchair students) was placed in a long basement window areaway, the window was converted into a door, a rather shallow door, and an interior ramp was built from the sill of the window to the basement floor. A false wall was also constructed as a corridor for the ramp. Within two weeks, 82% of all the faculty, staff and students that entered and left that building entered and left by way of the ramp we had built into the basement window of the building. Incidentally, there are several other entrances to this building.

"The foldaway shower seats which make it possible for an ambulatory person and a wheelchair person to use the same shower stall, quickly and in any order, were expected to last several years. Upon wearing out the first set of seats in less than six months, an investigation revealed that all of the able bodied students preferred to use the showers with the seats down. There are many other examples of this nature." —*Timothy J. Nugent, Director, Student Rehabilitation Center, University of Illinois, in his report on "The Design of Buildings for Use by the Physically Handicapped," at the Building Research Institute, Conference on New Building Research, Nov. 15-17, 1960, Washington, D.C.*

Training Courses Given for Staff Aides for Crippled Children In England and in United States

THE CENTRAL Training Council in Child Care *(Horseferry House, Thorney St., London, S.W. 1, England)* has made training facilities available as of September, 1960, to workers in homes and schools for children handicapped by physical defects, mental retardation, or maladjustment. Training includes refresher courses formerly limited to housemothers and housefathers in homes for deprived children and the basic one-year course leading to the Council's certificate, which is being expanded to fit special needs. The University in Bristol is offering a pioneer year's course for senior workers already holding some recognized qualification in the education or care of children. Information on courses and on grants payable to students may be obtained by writing the Council.

In the United States, the Child Welfare League of America *(345 E. 46th St., New York 17, N.Y.)* serves as a clearinghouse for information on houseparent training. The League in February, 1960, sponsored a three-day institute that was attended by 26 persons responsible for houseparent training courses offered in 14 universities. The pamphlet *Training Courses for Cottage Parents in Children's Institutions* (Nov., 1960. 23 p. 75¢) summarizes the proceedings of the meeting. *Cottage Parents: What They Have To Be, Know, and Do,* by Hyman Grossbard (Nov., 1960. 29 p. 85¢), a paper presented at the institute, is also available from the League.

3,000 Delegates Gather for White House Conference on Aging

THE WHITE HOUSE CONFERENCE on Aging held January 9 to 12 in Washington, D.C., anticipated an attendance of some 3,000 delegates from 53 states and territories and about 300 national vountary organizations. The Conference is taking up virtually all needs and problems of the older citizens of the United States, especially those of health, employment, income, housing, and free-time activities. Actions are being recommended to meet the needs—on the part of communities, states, the federal government, private organizations, and older people themselves. Dr. Leonard W. Larson, president-elect of the American Medical Association, is head of the discussion section on health and medical care, while Charles I. Schottland, former Social Security Commissioner and present Dean of the School of Social Welfare at Brandeis University, leads the section dealing with financing of health services. The rehabilitation section is headed by Dr. Howard A. Rusk, that on medical research in gerontology by Dr. Ewald W. Busse and that on biological research by Dr. Hardin B. Jones.

The December issue of *Rehabilitation Literature,* which featured Alexander Kira's article on "Housing Needs of the Aged," was planned for special distribution at the exhibit of the National Society for Crippled Children and Adults at the White House Conference.

Violet M. Sieder Comments on

The Citizen Volunteer and The Democratic Society

"A COMMUNITY is characterized by the quality and scope of its education, health, and welfare institutions. When these are understood, used, supported, and shaped by the citizens, a democratic society is in good health. When responsibility for its institutional life is delegated entirely to employed officials, whether under public or voluntary auspices, a precious part of our heritage is lost, and services fail to make their full impact upon the community."—*From "The Citizen Volunteer in Historical Perspective," by Violet M. Sieder, in* The Citizen Volunteer; His Responsibility, Role, and Opportunity in Modern Society, *edited by Nathan E. Cohen (Harper & Brothers, 49 E. 33rd St., New York 16, N.Y. 1960. 267 p. $4.75).*

Campus Transportation At Illinois Expanded

CAMPUS TRANSPORTATION for physically handicapped students at the University of Illinois has been doubled with addition of two more buses whose front doors have wheel chair lifts instead of steps. The four-bus fleet serves 163 handicapped students; 101 are in wheel chairs. Floor space in each permits 16 wheel chair students to ride in their own chairs and 13 other passengers in conventional seats. Marmon-Herrington Corporation, Indianapolis, Ind., which built the two new buses, plans regular production of lift-equipped buses for the physically handicapped. These four buses are operated at Illinois by the Student Rehabilitation Center. Each makes a complete circuit of the campus every hour, operating much as a city bus system. Special trips take handicapped students to and from church and to special events. Each bus travels more than 1,000 miles per month.

VA Asks Community Help To Organize Half-Way Houses

THE ESTABLISHMENT of "half-way houses" for recovering mental patients in communities where VA hospitals are located will be encouraged by the Veterans Administration. Dr. J. F. Casey, VA director of psychiatry and neurology service, stated that the number of houses set up will depend on the voluntary and civic groups in local communities and their co-operation with the program. The "half-way house" is thought particularly suitable for some patients long hospitalized for schizophrenia who do not need the care and attention of the hospital or a foster home but do need help in making the final break from dependency, while receiving some aid from the hospital social worker or psychiatrist.

National Directors of Special Education Resign

FOR THE PAST DECADE Harley Z. Wooden has served as executive secretary of the Council for Exceptional Children, a department of the National Education Association. Mr. Wooden has announced his resignation effective next summer. The first to hold the position of executive secretary, he is also the founder of the official journal *Exceptional Children* and was its publisher and editor for the years 1934-1940. Mr. Wooden is the chairman of the screening committee appointed by the Council to recruit his successor. The CEC, with a membership of 15,000, has a headquarters staff of 11 located in the NEA building, 1201 16th St., N.W., Washington 6, D.C.

After almost seven years' service as associate secretary for the special education department of the National Catholic Educational Association *(1785 Massachusetts Ave., N.W., Washington 6, D.C.)*, the Rev. William F. Jenks, C.SS.R., was recalled Sept. 15 for other duties by the Redemptorist Fathers. The Rev. Elmer H. Behrmann, director of special education for the Archdiocese of St. Louis *(4472 Lindell Blvd., St. Louis 8, Mo.)* was named associate secretary as Reverend Jenks's successor. Reverend Behrmann will continue his work with the Archdiocese. NCEA correspondence pertaining to special education should be sent to him at the St. Louis address.

Rehabilitation Counselor Traineeships Available

SAN FRANCISCO STATE COLLEGE will offer traineeships for graduate study leading to the M.S. degree in rehabilitation counseling for Fall, 1961-1962. One-year traineeships of $1,800 are usually renewable for the second year. Graduates of the 2-year graduate training program, one of 30 throughout the United States partially supported by the U.S. Office of Vocational Rehabilitation, will be qualified for positions with state vocational rehabilitation services, rehabilitation centers, sheltered workshops, hospitals, and other public and voluntary agencies. Salaries for graduate rehabilitation counselors without experience start at approximately $6,500. Graduates with experience have obtained positions at salaries between $7,000 and $8,500.

Traineeship application forms for the Fall term should be obtained by May 1st from William M. Usdane, Ph.D., Head, Department of Special Education and Rehabilitation Counseling, San Francisco State College, 1600 Holloway Ave., San Francisco 27, Calif.

U.S. Children's Bureau To Plan Child Welfare Research

SOME 20 EXPERTS in the child welfare field conferred with U.S. Children's Bureau officials Dec. 15 and 16, 1960, to discuss effective ways to enhance accomplishment in the child welfare field through research. The planning meeting was a first step toward implementing the recent Social Security Act Amendment that gives authority to the Secretary of Health, Education, and Welfare to make grants for research or demonstration projects in the child welfare field.

Under the terms of the Amendment, grants may be made to public or nonprofit institutions of higher learning or to those engaged in research or child welfare activities in order to establish special research or demonstration projects in the child welfare field. Such projects must be of "regional or national significance." Congress has not yet appropriated funds for the research program.

Dr. Polani Appointed Professor Of First Chair of Child Health

DR. PAUL E. POLANI has been appointed professor of the newly established chair of the National Spastics Society, England, designated the Prince Philip Chair of Paediatric Research. The Society allocated £2 million for establishment of the Chair and for a program of research on child health and cerebral palsy. The Chair, the first of its kind in the world, is at Guy's Hospital, the University of London.

Professor Polani, the Society's director of research, has been active in child health for 20 years. In 1955 he was appointed the research physician on cerebral palsy to the Society, and in 1958 he became director of its medical research unit in the department of child health at Guy's Hospital Medical School, a post he held until his recent appointment.

Federation of the Handicapped Celebrates 25th Year of Service

A DISTINGUISHED SERVICE AWARD was given to Dore Schary, producer, director, and playwright, at a dinner held Dec. 12, 1960, to celebrate the 25th anniversary of the Federation of the Handicapped *(211 W. 14th St., New York 11, N.Y.)*.

The award, presented by the President's Committee on Employment of the Physically Handicapped, was for Mr. Schary's efforts to portray the fitness of the disabled to lead productive lives. *Sunrise at Campobello,* by Mr. Schary, is a successful Broadway play and motion picture, which deals with the period of Franklin Delano Roosevelt's life when he became a victim of poliomyelitis. Ralph Bellamy, who played the role of President Roosevelt, is financial chairman of the Federation.

A special Emblem of Achievement was presented the Federation by the Community Council of Greater New York for its 25 years of service to New York's handicapped. The plaque was presented by Carl M. Loeb, president of the Community Council, to Dr. Leo Mayer, orthopedist, who has been president of the Federation of the Handicapped since 1942.

Willis C. Gorthy Dies

WILLIS C. GORTHY, director of the Institute for the Crippled and Disabled and a world authority on the rehabilitation of the handicapped, died on Dec. 4, 1960, after a short illness at his home in Scarsdale, N.Y. He was 52 years old. Mr. Gorthy joined the Institute as associate director in 1949, becoming its director in 1953. During World War II, he served as a colonel in the Office of the Chief, Transportation Corps, U.S. Army. Prior to the war, Mr. Gorthy was associated with the Tennessee Valley Authority, concerned with long-range planning problems. Interment was at Arlington National Cemetery.

Mortality Rate Lowered In Open Heart Surgery

DOCTORS AT THE University of Michigan Medical Center have brought the mortality rate in open heart surgery down to 1.4 percent for "uncomplicated congenital cardiac defects," according to a report in the *Journal* of the State Medical Society for November, 1960. The present 1.4 percent compares with the risk of a gall bladder operation. The report was written by four U-M specialists: Drs. Herbert Sloan and James Mackenzie of the Department of Surgery and Aaron Stern and Joan Sigmann of the Department of Pediatrics. They summarize the results of 360 open heart operations performed at the U-M Medical Center during the past four years. The operation was first used on humans about six years ago after extensive trials with animals.

The operation should take place when the child is between 3 and 5 years old unless it is a matter of life and death to do it earlier. The typical open heart operation requires a team of about 12 doctors, nurses, and specialists. Elaborate preparations are required to connect the blood stream with the pump-oxygenator so the machine can take over the functions of the heart and lungs. Numerous other instruments are brought into play to give the surgeons a continual flow of vital information during the course of the operation. These include blood pressure readings, electronic measurements of the heartbeat and brain waves (EKG and EEG), body temperature readings, information on the oxygen content of the blood, and a detailed accounting of blood loss and replacement.

Conference on Basic Research and Paraplegia To Meet in Los Angeles

A CONFERENCE "Recent Contributions of Basic Research to Paraplegia," will be held in Los Angeles Feb. 17 and 18 by the Los Angeles Society of Neurology and Psychiatry, with the collaboration of the California Spinal Cord Foundation. Foremost investigators in basic research in North America will make presentations; the researchers and leading clinicians will hold a round-table discussion on implications of basic science research for clinical paraplegia. The Paraplegia Center at the Veterans Administration Hospital at Long Beach will be visited.

The number of persons invited to attend will be determined by limits of seating capacity. Programs and information can be obtained by writing Robert P. Sedgwick, M.D., Secretary-Treasurer, Los Angeles Society of Neurology and Psychiatry, 2010 Wilshire Blvd., Los Angeles 57, Calif.

Workshop for Deaf Groups Planned for April

A WORKSHOP ON LEADERSHIP and community participation among the deaf will be sponsored by Gallaudet College, on April 24 to 26, 1961. The purpose of the workshop is to create among a representative group of leaders of organizations of deaf people an awareness of the need, resources, and rewards for aggressive voluntary public service and to encourage these leaders to plan ways and means of promoting such activity in existing organizations of the deaf.

Fifty persons, invited to participate, include representatives of national organizations of the deaf, leaders of local and state organizations, and six leaders with normal hearing who are in charge of national and local community and social service organizations.

Alan B. Crammatte, chairman of the Department of Business Administration of Gallaudet College, is co-ordinator of the workshop. The workshop is being supported by a grant from the U.S. Office of Vocational Rehabilitation.

Change of Address

BENEFIT SHOE FOUNDATION, Providence, R.I. To: Gardiner Avenue, Lincoln, R.I.